GUY'S
HOSPITAL
GAZETTE

NEW SERIES
VOL. 29.

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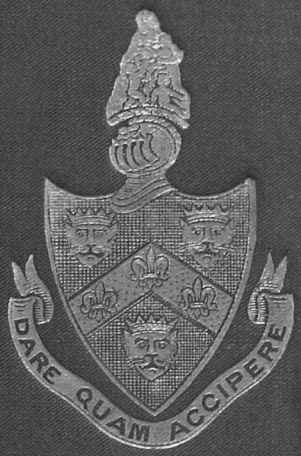
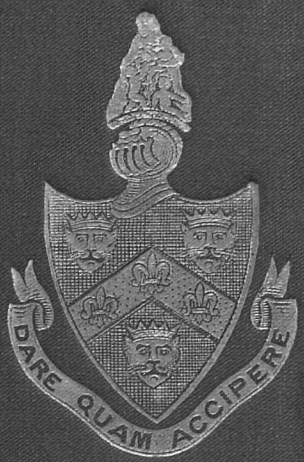


Guy's Hospital Gazette.



Guy's Hospital Gazette.

GUY'S HOSPITAL GAZETTE.

VOL. XXIX.

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Passim.

THE Christmas Festivities were carried out with the usual vigour and merriment. Such a memorable week of joy and happiness is made possible by the hearty and loyal co-operation of all the friends of Guy's—drawn from every phase of life to one common ideal—Sympathy.

It is the secret sympathy,
The silver link. the silken tie,
Which heart to heart, and mind to mind,
In body and in soul can bind.

His Majesty the King, our Patron; the President of the Hospital; Men of Commerce, of Professions, the Ladies, the Staff, Residents, Students, the Matron, Sisters and Nurses, and last, but by no means least, the Artistes who have entertained us so well. They have all played their part in our Christmas at Hospital and we are grateful to them. Let us now turn to the concrete results of this great bond. On Christmas Eve posters appeared in the Colonnade, as if by magic, announcing the various attractions to be held during the week. The wards were tastefully decorated and the results obtained have convinced us that the elaborate schemes of decoration so popular in former years are not essential.

ON Christmas morning there was great excitement in the College, and at twelve o'clock the Niggers were ready for their joy-day. After some delay, whilst Puppy Seabrooke adjusts his huge musical instrument on his shoulder, and P.C. 49. prepares himself for the day's ordeal, Massa Johnson (President Scott) marshals his merry men and they march into the Hospital, and are photographed on the Colonnade steps. The round of the wards was then commenced and did not finish until 8 p.m. Messrs. Blake and Muir Smith are to be congratulated on the all-round excellence of the troupe. The topical song by Messrs. Muir Smith and Groves caused great amusement:—

When the war started—this story is old—
The War Office wanted more beds, we were told;
Sir Cooper obligingly, not for a lark,
Offered to let them have huts in the park,
Out in the open;
With NURSES all passing,
With NURSES all passing,
And shouting "Hello."
But the War Office thought that with *such* great attractions,
Recovery might be abnormally slow.

THE Landon Christmas Tea was a great success. Over 700 children were entertained. Sister Out-Patients and her willing band of helpers are to be congratulated on the result of their hard work. At the conclusion of the proceedings Miss Mary Perry presented baskets of lilies to Miss Ellaline Terriss and Sister Out-Patients.'

THE Ward Concerts were up to their usua standard of excellence. Mr. Geoffrey Seabrooke, an old favourite, was in excellent voice. Miss Bateman and Miss Mitchell were in the wards every day, and Mr. Godfrey Tearle came down on Tuesday.

THERE was a general expression of regret at the absence of the Residents' Theatricals, but the Concerts arranged by Mr. George Parlby were very good indeed, and we have heard nothing but enthusiastic praise of them. Dr. Collisson, in songs and sketches at the piano; Mr. Edgar Coyle, vocalist; Mr. Fery Lorant, violinist; Mr. Arthur Helmore and Mr. Charles Pond brought down the house on both nights. The Concerts are still in full swing, and the Merry and Bright in Astley Cooper on New Year's Eve will conclude the most enjoyable Christmas we have ever spent at Guy's.

MAY we direct the attention of Guy's men to the letter from Dr. Hale White, Chairman of the Guy's Hospital Pharmacopœia Committee, in which an appeal is made for prescriptions and formulæ and other suggestions for the new edition of the Guy's Hospital Pharmacopœia which is being prepared.

The last edition appeared in 1899, so that it is very essential to make the new edition as complete as possible by including every drug and prescription which practical experience has shown to be useful in the treatment of disease.

MR. OLIVER JOHN WADE, only son of the late Dr. John Wade, Lecturer on Chemistry at Guy's, has been awarded an Open Entrance Scholarship of sixty pounds a year at King's College Cambridge. Mr. Wade has been a pupil at St. Olave's School for ten years. We wish him every success in his future career.

WE have great pleasure in announcing that Mr. Symonds, Consulting Surgeon to the Hospital, has consented to give three Lectures on Clinical Surgery on the dates allotted to Sir Alfred Fripp, namely the 13th and 27th of January, and the 10th of February.

THE Rubber Growers' Association continue their interest in the Hospital. Last week 100 rubber hot water bottles were sent by Mr. McEwen for use in the wards. The rubber flooring in Stephen Ward receives high commendation from the wounded officers, and it would be a great and lasting improvement to put this ideal flooring down in the other wards.

WE congratulate Dr. F. Gowland Hopkins, University Reader in Chemical Physiology, on his election to the newly constituted Professorship of Biochemistry in the University of Cambridge.

WE regret to hear that Captain Malcolm Leckie, D.S.O., R.A.M.C., died from wounds at Frameries, near Mons, on August 28th. An obituary notice is published in this issue.

Second Lieutenant G. B. Monk, Royal Warwickshire Regiment, has been killed in action. Born in 1891, George Bernard Monk entered Guy's in October, 1913, as a Medical and Second Year Dental Student, having passed in June, 1913, the examination for the D.D.S. of Michigan University. At the time of enlisting he was studying Anatomy of Physiology.

Mr. Max Schneider has been killed whilst fighting for Germany. Born in 1882, at Gorlitz, he entered Guy's as a Dental Pupil in 1908, held the usual student appointments and dresserships, and was Dental House-Surgeon in 1913. He was awarded the Newland-Pedley Gold Medal for Practical Dentistry in 1912, and was elected to the Guy's Travelling Dental Scholarship in 1914.

THE following amusing answer was given by a boy in a general knowledge paper:—

> "Anatomy is the human body, which consists of three parts—the head, the chist and and the stummick. The head contains the eye and brains, if any: the chist contains the lungs and a piece of the liver: the stummick is devoted to the bowels, of which there are five—a, e, i, o, u, and sometimes w and y."

THE present issue of the GAZETTE opens a new volume, the twenty-ninth. An index and title pages for last year's volume have been prepared, and readers who wish to have their sets bound should send them to the Librarian.

The bindings are in two shades of blue, with the Hospital Arms in gold. We would also

remind our readers that subscriptions for 1915 are now due and should be sent to the Manager of the GAZETTE.

The Librarian also informs us that he has a large number of bound volumes of the GAZETTE from 1907—1913, and would be glad if they were taken away.

Several borrowed books have not been returned to the Library, so perhaps we may quote the following lines:—

If thou art borrowed by a friend
Right welcome shall he be
To read, to study, not to lend,
But to return to me.

Not that imparted knowledge doth
Diminish learning's store,
But books, I find, if often lent
Return to me no more.

Read slowly, pause frequently, think seriously, keep cleanly, return duly with the corners of the leaves not turned down.

JOHN B. FITZSIMONS.

A MEETING of the Guy's Hospital Missionary Society will be held in the Nurses' Home, on Thursday, January 14th, at 8.15 p.m. for the Election of Officers and other business.

DEATH FROM ANTHRAX.

STRANGE CASE OF A BUTCHER'S MANAGER.

The City coroner opened an inquiry on the 21st of December concerning the death of Charles Tarrant, aged 45, a butcher's manager, of Mitcham, who died in Guy's Hospital of anthrax.

It was stated that the deceased had handled meat obtained from a Croydon firm, who dealt in English and Argentine produce. He was also in the habit of skinning frozen rabbits. On the 12th inst. Tarrant complained of headache, and the same night a pimple appeared on the left side of his neck. His medical man diagnosed blood poisoning, and subsequently sent him to Guy's Hospital, where he died on Thursday. It was stated that a lad who had partaken of meat obtained from the same firm was now in Guy's Hospital suffering from anthrax, and that a man died of anthrax a few days since in the Croydon Isolation Hospital, while a son of the deceased's employer is now seriously ill, supposed from anthrax poisoning.

Dr. Danby, of Guy's Hospital, spoke to admitting Tarrant, who had a sore on his neck, characteristic of anthrax. The sore was excised, and the patient given a serum, but he died in spite of all treatment. Death was due to heart failure produced by the anthrax bacillus.

Dr. Legge, of the Home Office, stated that he had never heard of anthrax being caused by frozen rabbits. The disease generally attacked men who handled hides, goat skins and pigs' bristles. The witness said he was aware of the Croydon case, and the authorities of Guy's Hospital had furnished particulars of the case of the lad, who was getting better. Both the Croydon man and the boy were employed by the firm which supplied Tarrant's employer with meat. The inquiry was adjourned.

—*Morning Advertiser*, 22nd December, 1914.

DENTISTS MORE DREADED THAN SHELLS.

Mr. F. Newland-Pedley, consulting dental surgeon to Guy's Hospital, writes from Rouen to the *Lancet* appealing for a definite corps of dental surgeons. He says that since he arrived at Rouen as a volunteer dental surgeon nearly two months ago he has received cases from all quarters, Red Cross and general hospitals and convalescent camp included. "If the Government is prepared to send out enough dental officers a large number of soldiers can be saved to the Army."

A good supply of "gas" is necessary, for among the wounded, "when men are weak, they dread the dentist far more than they fear a 'Jack Johnson' when they are well."—*The Standard*, 21st December, 1914.

Obituary.

CAPTAIN MALCOLM LECKIE, D.S.O., R.A.M.C.
Died of wounds on August 28th, at Frameries, near Mons.

CAPTAIN MALCOLM LECKIE, formerly of Guy's Hospital, went to the front with the Expeditionary Army, being attached to the Northumberland Fusiliers. Before that period his short career in the service had been almost entirely passed in Egypt, where he left a high reputation for personal amiability, professional capacity, and devotion to duty. This latter quality he displayed in its highest form at the battle of Mons. "Those officers who were near him were enthusiastic in describing his fearless and reckless devotion in attending the wounded," says one witness. "He was most gallant and energetic," says another. In attending to an injured man in the open on August 24th, the first day of the retreat, he was struck by a shrapnel bullet high up on the breast. The missile seems to have penetrated to the spine and caused some paralysis. He was carried into the hospital at Frameries, a village some miles south of Mons, and there lingered for some days, attended by a Belgian doctor and nursing sisters from a neighbouring convent. It is said that even after reaching the hospital he continued to minister to some wounded who were brought to his bedside. On the fourth day after his injury he died, though it is only within the last week that his anxious relatives and friends have received detailed assurance of the fact. His conduct had already been recognised by the D.S.O.

So in his thirty-fourth year passed away a man whom it has been a privilege to know, and whose memory will linger as a beautiful and tender thing, in the minds of all his friends. What is mortal of him lies in the churchyard of Frameries. But those who recall that eager and sensitive face, that quick sympathetic smile, and gentle modesty of bearing will see in them the

expression of something more permanent than death—the true inner man of which matter is but the shell. The value of a career does not lie in length of years, and this young life, given unselfishly for others, has been a thing so complete and beautiful in itself that the grief even of his own nearest may well be softened by their loving pride.

Dec. 21st, 1914. ARTHUR CONAN DOYLE.

MALCOLM LECKIE entered Guy's in 1899, passed the Second Conjoint in January, 1903, and the Final in April, 1907; he then read for the R.A.M.C., which he entered in January, 1908. At Guy's he dressed to Mr. Golding-Bird, and was Clinical to Dr. Hale White and Dr. Pitt in the last three months of 1907.

During some three years in the Dissecting Room I got to know him well, and chiefly remember his keenness for everything he undertook; he was one of the first to take up hockey at Guy's and to establish it as a regular Hospital game.

He was typical of that fortunately common stamp of Conjoint man who makes public opinion among his fellows, and is respected and liked for himself and his manliness; I should say that Leckie spent himself for his friends, and recently talking over with one of his chums our recollections of him, we agreed that he was happiest when taking immense pains to do some small kindness to others, often for those who had but slight claim on his friendship. To those who knew him well he was always the same kind, generous, unselfish person, with rather a thoughtful manner and slow to express his own views; one can well imagine that his place in his Mess will remain unfilled, and many a sick or wounded soldier will know he has lost a friend.

C. H. F.

Sir ROBERT M. SIMON.

A PHYSICIAN who had filled a prominent place in the medical life of Birmingham—Sir Robert Michael Simon, F.R.C.P.—died on December 22nd, in his 65th year. Sir Robert had been identified with most of the philanthropic institutions of the city, and was for twenty-three years honorary physician of the Birmingham General Hospital. Since 1910 he had been Professor of Therapeutics at the Birmingham University, having previously been Examiner in Medicine at the University of Cambridge. Educated at Caius College, Cambridge, Guy's Hospital, and Berlin, he was the author of works on "Diseases of Brassworkers," the "Treatment of Common Diseases of the Skin," and of many contributions to medical journals. Sir Robert married, in 1887, Emily Maud, daughter of Mr. W. H. Willans, D.L., of Holland Park, London, and Seaton, Devon, and a first cousin of Mr. Asquith, who invariably stayed with Sir Robert when he visited Birmingham.

Residents' Concert.

OWING to the war, the absence of so many Guy's men in military and medical service, and the fact that those remaining behind are doing double duty, it was decided some time ago that the usual Residents' Theatricals could not take place.

No Theatricals! Could it be Christmas? One thinks with immense pleasure of the songs and dances, the Shakespearean suggestions of scenery, the topical illusions, beloved of all, even by the victims, the sisters and nurses with impossible waists and abnormal voices, of all the kindly host who have amused us year by year.

We remember, not so *very* long ago, a play in the Court Room, an ordinary printed play, into which a Guy's nurse was rather tentatively introduced into a railway station scene. A porter, whose Missis had been in the 'orspital, was advising her as to a special train, South Eastern, warranted only to stop twice between London Bridge and New Cross. Our recollection is that the nurse was not allowed to speak! The plays have certainly advanced since then.

As local talent was not available, the Residents are to be congratulated most heartily upon providing an evening's entertainment so crammed with song and jest, mirth, and jollity. Our thanks, as audience, are due to the long list of performers whose efforts, from the very first item on the programme, were tumultuously encored.

The last word of our plays has always been modernity. If Dr. "Bennett" Fawcett percussed a savage at this special season, 1913, it was Dr. Fawcett that counted, not the savage.

On Monday night we were plunged straight back into the old world of Dickens. The Cockney, and especially the Borough Cockney, brought it all before our eyes. The elements assisted with their very boisterousness, though, to be perfectly correct, we felt the setting should have been in snow. The humour of the streets and tavern, surely it was Mrs. Dilber who, after parting with her bundle to Old Joe, saw "Fish Face" looking at her as she drank, the dog-fancier and many other humans who walked these ways in other costumes and at other times, made an effective re-appearance. Withal, mention must be of "Zomerzet" songs, violin and cello solos, Mr. Wharton Wells, as pianist and most talented accompanist all through the evening, and the lovely voices of Mr. Whitworth Mitton and Mr. Edgar Coyle as they sang of the beauteous maidens and the sorrows of parting, far, indeed, from the casual "so long" of to-day.

We are sure that the devout lovers, the instrumentalists, and the jesters of "The George" joined with the audience in awarding the palm of the evening to the very spirit of Father O'Flynn who had crossed

the channel in the person of Dr. H. Collisson. His twinkling eyes, the kindly mirth suggested in his appearance, his quips and tales, and all that he and the piano could do together will long be remembered as a very sunny spot in a Christmas Season that could not hope to contain all the usual brightness.

Notes and Comments on some Cases of Wounded Men from the Front.

By L. A. PARRY, F.R.C.S., B.S., Capt. R.A.M.C.T., Assistant Surgeon, Royal Alexandra Hospital, Brighton.

An Address delivered to Territorial Medical Officers.

GENTLEMEN,—I desire, as far as possible, to make my address to you of some practical value, and I, therefore, propose to discuss certain points which have arisen in connection with the treatment of the wounded from the front which appear to me to be likely to be helpful.

I will commence my remarks by a few words on the subject of *Secondary Hæmorrhage*. This is not a very common occurrence in ordinary civil practice, but it is far from uncommon following gunshot wounds, and is a subject of considerable importance, for on its correct and prompt management the life of the patient may depend. Secondary hæmorrhage in gunshot wounds is most common in the second and third weeks after the infliction of the injury, and is almost always due to sepsis. It follows, therefore, that it is more frequent after shrapnel wounds than it is after rifle bullet wounds. The principles of treatment are fairly agreed upon by most surgeons now, but in individual cases there may often be some difficulty in deciding the best course to pursue. Pressure, tourniquets, gauze plugging, etc., should only be used as temporary measures; they are useless methods to employ for the permanent arrest of bleeding.

The first cardinal principle of treatment is that, whenever possible, the hæmorrhage should be stopped by ligature of the bleeding vessel in the wound. This should be opened up, and both ends of the divided vessel searched for and tied. In sloughy septic wounds this is often no easy task, but with care and patience it can, in a large number of cases, be accomplished. If this is impossible, and in a certain percentage of instances it is, the choice lies between proximal ligature of the main artery and amputation.

Here is one on the horns of a dilemma. If proximal ligature is decided on, and the bleeding is thereby checked, it means that there is practically no collateral circulation, that there is a considerable risk that gangrene may follow and that amputation may have to be carried out under less favourable circumstances. If the collateral circulation is free, and thereby the risk of gangrene obviated, the hæmorrhage may not be stopped, and again amputation must be undertaken under conditions less favourable. In most cases when ligature at the bleeding point is impossible, it is, I think, wise to attempt to save the limb, and resort to proximal ligature of the artery. If this cause gangrene or fails to check the bleeding, nothing is left but amputation.

I will quote a few cases to illustrate these principles of treatment, and I should like here to say that although the great majority of the examples to which I shall refer in the course of this lecture have been under my own care, I am indebted to my colleagues for permission to refer from time to time to cases which have been treated by them.

The first case is that of a man who was shot in the shoulder joint, the wound causing a compound comminuted fracture of the upper end of the humerus. Soon after admission there appeared suddenly a large subcutaneous hæmatoma in the pectoral region, and from the man's condition it was clear that considerable bleeding was going on. The swelling was incised and furious hæmorrhage was found to be taking place, but it was impossible to find or secure the actual bleeding point. The subclavian artery was therefore ligatured. He did quite nicely for a short time and then the bleeding began again and was repeated on many occasions. It was plain, then, that the collateral circulation had become freely established and, therefore, the ligature of the main vessel had failed in its purpose. The man was in a very bad state and nothing was left but disarticulation at the shoulder joint.

In another case there was a septic wound of the knee joint from a bullet wound, and violent hæmorrhage occurred from the popliteal artery quite suddenly. A tourniquet was applied at once which stopped the bleeding, and here it was clear that nothing but amputation would be of any use. The leg was accordingly removed at the lower third of the femur.

In the next three cases, in which the bleeding vessels were branches and not main trunks, the treatment successfully adopted was ligature in the wound. The arteries affected were the anastomotica magna, the external pudic, and the circumflex iliac. In the latter, the injury was in the groin and had opened the bowel. The wound was very foul from fæcal contamination, but no difficulty was experienced in finding and tying the artery.

In a further instance the bullet had traversed the nose, cutting through the palate, and then passing down the side of the neck, and lodging behind the sterno-clavicular articulation. It had concussed the brachial plexus, and also wounded the apex of the lung. All went well for about ten days, when the man was seized with hæmorrhage from the palate, after separation of a slough. This was easily checked by pressure, but occurred again. He died in a few

hours, not from hæmorrhage, but from asthenia. He was in a very exhausted state on admission from inability to swallow any food.

Another example I may mention is of a man who had a bullet wound of the neck, the missile entering just above the centre of the clavicle, passing backwards, and lodging in the muscles of the neck. The clavicle was badly comminuted. Secondary hæmorrhage of a quite slight nature occurred twice, but was easily stopped by plugging. It is intended to remove the bullet, when it is hoped that the septic sinus will heal and obviate any further danger from bleeding.

In another case there was sudden excessive bleeding without any warning, from the wound, in the case of a man who had been shot through the upper arm. The main vessel was at fault, and he bled to death almost immediately.

In a last instance, the wound was in the arm, and the bleeding was from a branch of the brachial artery. This was ligatured in the wound, but bleeding recurred, and amputation had to be performed.

We have had a large number of very *extensive wounds of soft parts*. As a rule these cases arrive in a very septic or sloughy condition, but they do exceedingly well with treatment, cleaning up very rapidly and healing nicely. As examples of the method of treatment which I generally adopt, I will quote briefly a case.

A man was struck by shrapnel on the back of both legs. On the posterior aspect of the left thigh the muscles were exposed, and there was a large raw surface, twelve inches by six, suppurating freely. There was a similar wound slightly smaller on the back of the right calf. The treatment adopted was to irrigate with ten volumes per cent. of hydrogen peroxide, then cover with gauze soaked in chlorinated soda solution. This, together with rest and good food, led to very rapid improvement in the appearance of the wounds. I may mention that in this case, as in so many other instances of septic wounds, the temperature rose irregularly without apparent cause, even up to 105. This is due, I think, without doubt, in the great majority of cases, to septic absorption. But one must not assume this to be always the cause. For instance, a man had a septic wound of the thigh which had nearly healed. His temperature went up to 105. It did not seem likely that the pyrexia was due to his wound. None of his organs appeared diseased, but his urine was examined bacteriologically, when it was found full of coli bacilli.

This method of managing superficial septic wounds is simple, but it is certainly effective. I have treated many cases in this way and am quite satisfied with the results.

Penetrating Wounds of the Chest.—In the great majority of penetrating wounds of the chest, the lung must be injured. The symptoms may in some instances be quite slight, in others very severe. They consist briefly of shock, varying from the slightest to the most grave form, pain, breathlessness, cough, and hæmoptysis. This latter symptom may arise, it should be remembered, from simple contusion of the chest wall, without any penetration. Even when due to a bullet injury it is rarely severe, and usually lasts only a few days. Surgical emphysema is not very common. Complications such as hæmothorax, pneumothorax, and empyema are not uncommon, and make the prognosis much more serious. Pneumonia sometimes occurs, and is then generally due to exposure rather than to the injury, the unwounded lung often being the one attacked. The bullet frequently lodges in the chest wall, but rarely in the lung itself.

The treatment is simple, and in those cases in which there are no serious complications a policy of masterly inactivity is the best. Bullets, unless very superficial, should be left alone in most instances. Fluid should be aspirated, but this must be done with the very strictest antiseptic precautions, as otherwise a simple pleuritic effusion may be converted into a purulent one. Empyema should be treated by resection of rib and drainage on the usual lines.

The following cases which have been under my care illustrate various points to which I have referred:—

A man was shot right through the chest, the bullet entering at the back about the angle of the scapula, passing right through the lung, and remaining fixed in the front of the chest wall, just over the second rib. The man began to spit blood directly after he was wounded. On admission his condition was as follows: The hæmoptysis had ceased, his general aspect was quite good, his temperature about 100, but the whole of one side of his chest was dull to percussion, the breath and voice sounds were almost absent, and it was evident that the pleural cavity was full of fluid. The bullet could be distinctly felt in front. This was removed. It was found lying free in a small abscess cavity. This, I am told, is often the case. Suppuration occurs only at the place of lodgement of the ball, and not in its course. The chest was explored, and a good deal of blood-stained pleural effusion removed. The man made a rapid and uneventful recovery.

A man was shot by a rifle bullet through the nose, the missile passing down through the mouth, the side of the neck to the upper part of the chest. In its course it passed through the apex of the lung and and caused slight surgical emphysema just above and below the clavicle. As regards the lung injury, it was only very slight, and caused no more trouble, although the man died later from other lesions.

In the next two cases the bullet remained lodged in the lung. The first man was shot at close range, about 300 yards, the ball entering over the seventh rib in the mid axillary line. An X-ray plate showed it embedded in the lung. The man did not seem ill, but he had bad turns occasionally. He spat up a good quantity of reddish pus, and his temperature ran

up to 104·6°, and kept elevated for about six weeks, then gradually fell to normal. No attempt was made to extract the bullet, and the patient gradually got better. His temperature has now been normal for some time, and he is perfectly well.

In the second case much the same story is repeated. He was struck by shrapnel, the bullet entering at the angle of the right scapula, and remaining in the chest. He was rather ill in himself, and had extremely exhausting paroxysms of violent cough at frequent intervals. There was very profuse expectoration. A good deal of his lung trouble was due to a general bronchitis, which had preceeded his wound. He had for some days been exposed to very bad weather in the trenches. His temperature was up to 103·6, and kept up irregularly for five weeks. Now he has immensely improved, in all respects, his temperature has been normal for some time, and he is practically well. These two cases illustrate the wisdom of patience in the treatment of bullets in the lung. A search for them is, as a rule, a difficult, prolonged, and dangerous operation, not by any means certain of success, and one not to be undertaken lightly.

Another case is that of a man who was shot in the back, the bullet entering over the twelfth rib, just external to its angle, and making its exit above and internal to the nipple. It must, in its course, have passed through the liver and lung. The wound of entry has healed, but that of exit discharges profusely. There were all the signs of fluid in the chest, pyrexia was present, and the man looked ill. A needle was inserted, but only blood-stained serum was found.

A last case is that of a man shot in the neck, the bullet entering just above the sterno-clavicular articulation, passing downwards, outwards, and backwards, and making its exit at the angle of the scapula. It must, from its direction, have traversed the lung, and this is also evidenced by transient hæmoptysis, which lasted only twenty-four hours after the reception of the injury. Both entry and exit wounds soon healed, and all that is now left is dyspnœa on exertion. This is a common and often troublesome and prolonged after-effect of bullet wounds of the lungs. It is probably due to pleural adhesions or to contraction of the scar in the lung, and often the patient is incapacitated for a considerable time by it.

Frost Bite.—There have been several cases of frost bite recently admitted from the trenches in the neighbourhood of Ypres, occurring during the bad weather at the end of November. All the men tell the same tale: days of practically continuous duty in the trenches, with no opportunity of changing or drying their boots, socks, or feet. The trenches were waterlogged, snow and hail often making matters worse. This cold, wet, and exposure, day after day, caused frost bite of the feet (in all cases this was the part affected), varying from the first degree to actual gangrene. In one case the front half of both feet were so bad that amputation will have to be performed later.

The following cases were then demonstrated in the wards:—1. A case of bullet wound of the thigh. 2. A bad case of frost bite, causing gangrene of both feet. 3. A case of bullet wound of the lung, followed by dyspnœa on exertion. 4. A case of shrapnel wounds of both legs. 5. A case of frost bite. 6. A case of wound of lung and liver. 7. A case of wound of kidney. 8. A case of gutter wound of face causing blindness from concussion of the optic nerve. 9. A case of compound fracture of the radius by a bullet. 10. A case of compound fracture of the lower jaw. 11. A case of compound comminuted fracture of the clavicle. 12. A case of bullet wound of the hand necessitating amputation; and many other examples of bullet wounds and other injuries.

Pass List.

University of Oxford.

At a congregation held on December 12th, the following medical degree was conferred:—

B.M.—L. R. Broster.

The following candidates have satisfied the examiners in the undermentioned examinations:—

SECOND B.M., B.Ch.

Materia Medica and Pharmacology.—E. W. Bowell.

Pathology.—E. W. Bowell, R. W. J. A. Cushing, A. G. East.

Forensic Medicine and Public Health.—E. W. Bowell, L. R. Broster, R. W. J. A. Cushing.

Medicine, Surgery, and Midwifery.—L R. Broster.

Royal College of Surgeons.

The Council, at its meeting on December 10th, conferred the Diploma of Member upon the following gentleman:—J. Hales Parry.

Beit Memorial Fellowships.

At a meeting of the trustees of the Beit Memorial Fellowships for Medical Research, Dr. E. P. Poulton was elected a Fellow. The Fellowships are each of the annual value of £250, and usual tenure is three years, but an extension of one year may be granted by the Trustees in exceptional cases. The research proposed by Dr. Poulton is Respiration and Metabolism in Disease. Place of research—the Laboratories of Guy's Hospital Medical School.

University of London.

2ND EXAMINATION FOR MEDICAL DEGREES.

Part I.—Organic and Applied Chemistry.

M. Ba.Thin. C. C. Bennett. C. G. Coombs.

Some Interesting Cases in General Practice.

DURING the past few months I have had through my hands a number of cases so interesting as I hope may justify their publication.

A man, aged fifty-six, fifteen years ago had a severe attack of gall-stone colic. For a few days before I was called to him he had not been well. He was markedly jaundiced. Hoping that it was an obstructive lesion, after three weeks I sent him up to the Hospital. Mr. Steward on operation found cancer of the gall-bladder with secondaries in the liver. As too frequently happens for the peace of mind of the G.P. the man one day showed every sign of impending death—he revived and lived a week. This case occurred immediately after I had read Dr. Fawcett's paper in the Reports, stating that cancer was a sure sequel of gall-stone trouble.

A young woman of thirty was sent home from India, having had her right breast removed for cancer. A week after she reached England a small mass was found in the upper segment of the left breast. This I removed, on section it was found to be carcinoma. On examination it was found that she exhibited clear signs of involvement of the spine, inhibiting the use of her left leg. She was removed to Liverpool that she might die with her people. It is now nearly six months since I removed the little tumour, and she has completely recovered the use of her left leg without any treatment whatever, and is fairly well.

The third is a case of great interest. Nine months ago a man of 56 came to me with a large carcinoma linguæ, without ulceration. He was sent to Mr. Dunn, who decided that the disease was too advanced to justify removal. A few months later the submental glands were removed. Two days ago I saw him, he was then fairly well and the carcinoma remained as before, and the cellular submental thickening was much reduced. A cancer-cure on this case would have scored greatly.

A man of forty-six, old looking, was invalided home from India because of uncontrollable attacks of gastralgia every two or three days. A year ago I was summoned in a great hurry and found him suffering from a severe attack of angina pectoris. He passed into the hands of my partner, who, with two consultants, agreed that it was pseudo angina, and that his gastric attacks were due to excessive tobacco and whisky. Under treatment he somewhat improved until one day I was called to him with a very violent attack of pain in the epigastrium spreading into his cardia and down his left arm. His pulse was regular, about 120 per minute. During that day so severe was the pain that I had to give him chloroform and 2½ grs. morphia hypodermically. Suddenly it struck me that I had been looking at a case of gastric crisis with cardiac involvement. Dr. Shillitoe saw him with me and agreed. We found that twenty years ago he had had symptoms which suggested syphilis, for which he had been treated for a year. He was put on iodide and mercury suppositories, and has had no more cardiac attacks and is very generally better. There are no tabetic signs. Always think of syphilis, it may cause *anything!*

The troubles that any patient may endure are well illustrated in the case of a young mother separated from her husband. A few months ago I cut off her tonsils, severe hæmorrhage followed. With adrenalin to the tonsil, and copious rectal injections, I saved her life. Then her second child died. Three months later, looking very well, she came to me complaining of amenorrhœa and a vaginal discharge. She was pregnant. An abortion-monger in Soho cleared her uterus. The discharge was gonorrhœal. A little while later she appeared with a Hunterian chancre close to the anus and a secondary rash. She received three salvarsan injections. A little later she sent for me on the third day of an appendicitis attack; I released a considerable abscess, but was unable to remove the appendix.

On the ninth day a stercolith was discharged through the wound. A week ago she complained of deafness in the right ear. It proved to be auditory nerve deafness. Although nought is said about this in the books—it occurs as a result of salvarsan—I know of another case. Thus the result of one "indiscretion" has been gonorrhœa, a baby, syphilis, and a deafened ear. The cause was killed in the war!

A man, aet 29, came with a complaint of pain about his left hip, due to a strain. He improved with a liniment. Then he had abdominal discomfort, due to a fortnight's constipation. He improved on relief of this. Two days later a mass was felt in the left inguinal region. On operation it was carcinomatous. Later he had obstruction and a colostomy was performed—he died in three days. At an autopsy the tumour was found to have arisen in the wall of the colon. Seven weeks after a complaint of strained hip he was dead. Strangely varied is the age of cancer. VAUGHAN PENDRED.

Change of Address.

C. H. Stainer, P.O. Box 84, Middelburg, Transvaal.

(The Editor will be very glad to receive a post card with notes of any change of address.)

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Calcification.

CLINICAL LECTURE BY J. HOWARD MUMMERY, M.R.C.S., L.D.S.

GENTLEMEN,—I have been requested by my friend Mr. Hopson to deal with the subject of Calcification, forming part of his lectures on Dental Histology. I am deeply sensible of the honour conferred upon me by this request, and while I feel sure that his great experience in teaching would enable him to explain it much better than I can—I will endeavour to put before you what is known in this somewhat obscure region of dental histology, and also to demonstrate by the help of the lantern, my own humble endeavours to shed further light on this difficult subject.

In both dentine and enamel there is an organic foundation or scaffolding laid down in which calcification of the tissues takes place. However completely this organic matter may be impregnated with the salts, and however thoroughly it may be lost sight of in the finished tissue, it is still there, and is often brought into view by imperfect consolidation or by the action of certain reagents. In the case of dentine the scaffolding is derived from the connective tissue of the pulp, and passes as fine fibrillæ, more or less horizontally, into the forming dentine.

Professor Von Ebner, of Vienna, showed long ago that fibres were incorporated in the matrix of dentine, and compared calcification of dentine with that of bone.

In a paper published in 1892 I described the incorporation of the fibres of the pulp in the forming dentine, but while Professor Von Ebner considered these fibres were derived from the odontoblasts I endeavoured to show that they arose from the connective tissue cells of the dentinal pulp.

A study of the formation of the shell of crustaceans (as first carried out by Rainey) showed very clearly that a similar organic fibrillar foundation is found in these lower organisms.

Professor Von Korff, of Kiel, long after Von Ebner's and my own investigations, published a paper on the fibres in dentine claiming that he was the first to show that there was an organic fibrillar basis in that tissue.

Teutonic culture (spelt with a K) is apt to make claims that it is somewhat difficult to substantiate, but while Von Korff certainly was not the first to draw attention to this fact, he succeeded, by certain methods of preparation, in developing teeth, in showing corkscrew-like bundles of fibres which traversed the pulp, spreading out in a fan-like form as they approached the dentine and becoming incorporated with it. He describes these fibres as passing into the dentine at right angles to the surface.

In a prolonged controversy, Von Ebner claimed that this was not the case; the corkscrew bundles of Von Korff, when they reach the dentine, spread out right and left in its substance parallel to the surface, and do not penetrate at right angles. I have made many preparations showing these fibres, and agree with Von Ebner that while they reach the dentine at a right angle to its surface, fibres at right angles to the surface cannot be seen in the dentine.

In enamel the density of the tissue makes it much more difficult to detect this organic foundation, but it none the less exists. Dr. Andrews, of Boston, was the first to describe an organic fibrillar matrix in enamel as fibres which passed from the ameloblasts into the forming enamel, these are the fibres that are seen to pass all across, developing marsupial enamel when calcification is commencing, and to form a framework, the prolonged Tomes' processes of the ameloblasts in which the deposit of lime salts takes place which forms the solid enamel prisms.

In the enamel of the rat, a fibrillar basis is also very evident. In sections of the developing teeth of the Kangaroo I have described fibres which, while also given off by the Tomes' processes, traverse the forming enamel more or less at right angles, forming a fine network crossing the prisms. There are, therefore, in enamel two sets of fibres, those passing directly out from the enamel cells in the Tomes' processes in the direction of the prisms, and finer fibres crossing the prisms.

I would therefore impress upon you that the hard tissues of the tooth are not merely a combination of the calcified substance with organic matter in a kind of indefinite mixture, but a deposit of the inorganic salts in a distinct organic structure, or fibrillar network.

Chemical substances in solution were, as you are aware, divided by Graham into crystalloids, or crystallizable substances and non-crystallizable substances or colloids. There is, however, no hard and fast line between crystalloids and colloids, but they gradually merge into each other, some colloids, such as the hæmoglobin of the blood being crystallizable, and some crystalloid substances being also capable of appearing in colloidal form.

Colloids are amorphous when in the solid state, and a colloidal solution consists of these amorphous particles in a very fine state of division held in suspension in the solvent. It is a kind of emulsion such as may be obtained in much coarser particles by shaking up oil in water.

It was found by Rainey and Harting that crystallizable salts of lime, when allowed to combine by slow diffusion through a colloid, such as albumen, instead of being deposited as crystals, assumed a globular form. These globules, named by Harting, calcospherites, are of various contours, some showing concentric lines as if built up of layers, others being quite globular in form, and showing radial markings only when breaking up, their disintegration taking place along these radial lines. In a repetition of Harting's experiments in albumen I obtained an abundance of these calcospherites, both concentric and radial, the radial being in the greatest abundance.

Rainey, who made similar experiments, found that these spherites, which when first formed are more or less clear and structureless, when mature and about to undergo disintegration show their intimate structure much more clearly, the concentric and radiating lines being strongly evident. This observation has a very important bearing upon the process of calcification in dentine and enamel. When these calcospherites are subjected to the action of an acid, the lime salts are dissolved out, but they retain both their form and sculpturing, and although no longer refractile and not reacting to polarized light, they appear in every other respect to be unaltered. It is supposed that some portion of the lime salts has entered into combination with the colloid. This remaining substance Harting called "calcoglobulin,"

It must be remembered that the organic constituents of the body are chiefly in the form of colloids in the condition of "sols," as they are called, the reduction to the coagulated or "gel" condition leading to stasis or death of the part.

To sum up this part of my subject:—Lime salts which in watery solutions would be deposited as crystals, in a colloidal solution are deposited in the spherical form as calcospherites. These are chiefly concentric and radial in form, and retain their shape and marking after the action of acids, the substance of which they are composed being then called calco-globulin.

In order to study how far physical processes alone might be concerned in calcification I made some experiments in inorganic solutions, in the absence of all organic matter. For this purpose I studied osmotic growths under the microscope. An osmotic growth results from the diffusion of a salt in a colloidal solution. The salt when dissolving becomes surrounded by a pellicle or film formed by the colloid, as the solution proceeds, water from the surrounding medium penetrates the pellicle formed by the colloid by osmosis, and it becomes pushed out in the form of a tube; as the water continues to penetrate the membrane by osmosis the tube is rapidly pushed forward and often grows to a great length, ceasing, of course, when the penetration of the water from without establishes a condition of equilibrium.

After trying various substances generally made use of in procuring these growths, I found that crystals of copper sulphate dropped on the stage of the microscope, into a solution of silicate of potash in tap water (of course containing lime salts) gave the best results.

The extraordinary part of this experiment, however, was the production of transverse membranes in some of the tubes completely closing the diameter at that point, the further growth of the tube continuing a little way beyond the membrane and then ceasing in a closed end. What determines the formation of these membranes I do not know, and several eminent physical chemists to whom I have submitted the experiments are unable to explain it. When left for several days I found that these membranes acted as dialyzing membranes, and by the combination of the lime salts in the water large calcospherites were deposited in the part of the tube immediately beneath the transverse membrane. As you will see in the photograph, the upper part of the tube (on the side of the dissolving copper) contains crystals, presumably of silicate of copper and the lower part, calcospherites, probably composed of silicate of lime. The part below the membrane must then contain a colloidal substance, while above it the water has diffused through the tube walls and crystals are formed. While the formation of these transverse membranes is so difficult to understand, the fact which is of importance to us is, that lime salts can be diffused through an inorganic membrane and be deposited as calcospherites exactly as in an organic colloid such as albumen.

I hope I have not wearied you by these rather lengthy introductory remarks, but they are, I think, essential to the correct understanding of the subject.

We are familiar with the appearance of the growing margin in young teeth where calcification is in active progress. Between the odontoblast layer and the already calcified dentine is a clear

layer which is crossed by the dentinal tubes. Above this clear layer of uncalcified substance is a festooned line of rounded contours—the calcified substance of the dentine. Here and there isolated spherical bodies are seen in the clear layer. This rounded contour is formed by the coalescing calcospherites, and they are here quite clear and apparently structureless. In decalcified sections they retain their contours, but do not react to polarized light as they did before being subjected to the action of the acid.

This clear layer we conclude to consist of the colloidal material elaborated by the cells of the pulp, but it is to be noticed that the calcification does not proceed from the odontoblasts outwards, but encroaches from above more and more upon the clear layer or odontogenetic zone. This would seem to indicate that while the cells elaborate a material in which calcification takes place, probably containing some of the constituent salts concerned in the process, the actual operation which results in the fully calcified tissue takes place by a slow combination of the salts in this layer with other constituents dialized through the walls of the tubes, for we know that in artificial experiments calcospherites are only formed where slow diffusion is taking place and a condition of rest is maintained.

We know that the tubes are lined with a membrane, the sheath of Neumann, which is strongly resistant to the action of acids. This membrane, as pointed out by Irwin Höhl, appears to depend on calcification, as it is not seen lining the tubes in the odontogenetic zone, but only where calcification has commenced. The existence of this sheath has been denied by Römer, but I think his opinion must have been based on imperfectly stained preparations, for slides which I prepared also by the silver nitrate method show its presence quite clearly, and where the section is thinned off at the margin the lining membrane can be seen in the segments of tubes which remain.

The sheath of Neumann being of this indestructible nature, and the fact that it is only visible when calcification has commenced, would seem to indicate that it takes some active part in the process, and I have ventured the suggestion that it is really a dialyzing membrane through which are diffused some of the constituents of the calcified dentine supplied by the soft fibril in the tube which is a prolongation of of the body of the odontoblast cell. We know by the occasional closure of the tubes by calcification that calcifying material can be conveyed by the contents of the tubule.

I should, then, look upon calcification in the dentine as due to slow diffusion in the colloidal medium elaborated by the cells of the pulp—part of the calcifying constituents being supplied by the pulp, the other part supplied by the odontoblast processes, diffusing through the tube walls and combining with it to form the calcified dentine.

This would be analagous to what takes place in Professor Harting's experiment—where in a shallow dish containing egg albumen—a fragment of chloride of calcium is placed at one margin, and opposite to it a fragment of carbonate of soda. The two salts slowly diffuse through the medium and form the calcospherites of carbonate of lime.

I have little doubt that this view of mine will be looked upon by many as a sad heresy, but I have never seen any satisfactory explanation of the fact that the calcification proceeds downwards into the odontogenetic zone and does not commence exactly at the line of contact with the odontoblasts. According to the view I have stated this direction of calcification would be fully accounted for, and would also harmonize with the phenomena of the production of calcospherites in artificial experiments.

It will be remembered that I quoted Rainey's observation that in mature calcospherites "the lines are more distinct when the globules are suffering disintegration."

In dentine the first formed calcospherites at the calcifying margin are, as we have seen, clear and apparently homogeneous, but deeper in the dentine I found by the Cajal silver nitrate process in which the silver is reduced with hydrokinone, that lines in the calcospherites are very strongly marked, these markings are all concentric and not radial—they are of very various sizes, probably due to coalescence of the smaller first formed bodies.

The concentric lines seen within these bodies remain equidistant and never join those on either side of them, but what is especially noticeable is that in many parts these lines are seen to be extended horizontally and to form the fine laminæ of the dentine. The splitting of the section in thin parts always follows these lines of lamination.

It would appear that as calcification proceeds the rounded contours of the spherites become in the greater part lost in perfectly calcified dentine, and only these drawn out lines remain, as the laminæ of dentine, but these laminæ are also very obscure in the fully formed tissue.

This fine lamination of the dentine is often seen near the margin of carious cavities in

adult teeth—in the area where the micro-organisms have not yet penetrated, but where the acids of caries have preceeded their invasion. The effect of this acid upon the dentine has been to reveal or undo in some extent the process of calcification and the laminæ are brought into view.

I have had the slide now shown upon the screen for many years, having photographed it from a section of a carious tooth which was stained for micro-organisms. I asked several histological authorities if they could explain the meaning of it, but no one was able to throw any light upon it.

These silver nitrate preparations, however, give a definite explanation of the cause of these lines of lamination. It is interesting to note that these parallel lines correspond very completely with the similar lines in the crab shell which I showed you to be due to the coalescence of calcospherites containing the same striæ.

We will now consider the process of calcification in the enamel. Graf Spee, Leon Williams, and others have described globules in forming enamel, which they looked upon as an exudation from the cells of the enamel organ consisting of a material which afterwards undergoes calcification. These globules can be seen in the ameloblast cells and again beneath the membrane which separates the ameloblasts from the forming enamel (the inner ameloblastic membrane of Leon Williams). They may also be seen within the Tomes' processes of the ameloblasts and often in a fairly even row just within the forming enamel.

These globules do not react to polarized light and show no evidence of being calcified, but on examining a number of sections of marsupial developing teeth, cut without decalcification, I found that similar bodies deep within the forming enamel reacted to polarized light and were evidently calcified bodies.

Wishing to ascertain if such bodies could be seen in teeth which had not been subjected to any reagents, such as are necessary before section cutting, I procured a skull of a young kangaroo (*Macropus Rufus*) in which several of the teeth were still enclosed in their bony crypts. A very thin layer of enamel had been laid down over the cap of dentine. I scraped this enamel with a sharp knife into a drop of glycerine on the stage of the microscope and broke it up with needles—the enamel at this stage separates when merely touched with the needles into parallel laminæ like the leaves of a book.

They all showed the columns of prisms in an advanced stage of calcification, and many fragments showed accumulations of rounded bodies lying upon the laminæ and along their edges. A high power of the microscope showed these round bodies to be true calcospherites of the radial type, and many of them had split into fragments along these radiating lines, but not in a single instance was a concentrically marked calcospherite to be seen. These bodies showed double refraction when examined by polarized light exactly as do the calcospherites formed in the albumen experiments. By comparing these bodies with the photograph of the radial spherite formed in albumen you will see they are precisely similar bodies.

These slides also provide very strong evidence of the sequence of calcification in the enamel, for here we see well formed prisms with spaces between them—these calcospherites which are evidently actively engaged in the calcifying process lying between the laminæ of prisms. I think we must conclude from these appearances that the prisms are the first formed part of the enamel and that the interprismatic substance is calcified subsequently. This is of course directly opposed to the view of Mr. Charles Tomes, who considers that calcification takes place centripetally, progressing inwards upon the prism, the centre of which, according to his view, remains open as the tube in the tubular enamel of many marsupials. I regret I am unable to agree with him in these views, and in my paper, "On the nature of the tubes in marsupial enamel," I have given in detail my reasons for holding an opposite view. For the reasons before stated I look upon calcification in the enamel as a centrifugal process the prisms calcifying first, directly from the ameloblasts in the lines of the Tome's processes—the interprismatic substance, at first very imperfectly calcified, consolidating later. Confirmation of this view is obtained by an examination of the tubular enamel of marsupials.

In specimens prepared by injecting alcoholic fuchsine into the pulp cavity by the method of Von Beust, the stain is seen to have penetrated the enamel tubes and the wide spaces of the interprismatic substance, and you will see in the transverse sections that the enamel tubes lie in this stained area. The staining of these spaces, of course, indicates that there has been little or no calcification in this substance. The cross-cut tubes are seen, not within the enamel prisms, but between them.

The next slide is, I think, quite as conclusive, and shows the forming enamel in longitudinal

section. It was cut from the developing tooth of a kangaroo without being previously decalcified, but stained in bulk with borax carmine. The tubes are seen winding around the prisms, not within them, and in one place a rigid tube can be seen projecting from the surface of the section.

The view of calcification in the enamel which I have endeavoured to explain I may summarize as follows:—

Enamel is laid down as an organic framework by the Tomes' processes of the ameloblast cells which, as these cells recede, stretch across the forming enamel for its whole width, finer fibres passing in a transverse direction, and so forming with the prism-directing fibres a kind of network. The calcifying substance taken up from the blood by the cells of the enamel organ is dialyzed through the inner ameloblastic membrane and deposited in the form of minute globules within the Tomes' processes (as held by Leon Williams). These are regular bodies, and are built up like a row of bricks to form the prisms.

The enamel organ also supplies an albumenoid material which flows around and envelopes the forming prisms. This calcifies more slowly—the diffusion of salts from the enamel cells giving rise to the formation of calcospherites between the laminæ of the prisms. These coalesce and form larger bodies, and at a certain stage break up or disintegrate and become consolidated into the hard interprismatic substance of adult teeth.

In marsupials the slow, delayed calcification of this interprismatic substance admits of the penetration of the dentinal fibril, and the dentinal tubes run in these interprismatic spaces until finally closed in by calcification.

Time will not allow me to deal in this address with the chemical difficulties which meet us in considering the process of calcification in dentine and enamel, but I have considered these elsewhere* and suggested an explanation of the fact that calcospherites are deposited as such in tissues which when fully calcified show a large preponderance of phosphate over carbonate of lime.

* On the Process of Calcification in Enamel and Dentine. *Phil. Trans. R. Society B., Vol. 205 (1914).*

BOOKS, ETC., RECEIVED.—Edward Alanson and His Times, by R. W. Murrary, F.R.C.S., The London Hospital Gazette, St. Mary's Hospital Gazette, St. Thomas's Hospital Gazette, The New York State Journal of Medicine, The Hospital, The Nursing Times.

The Work of a Clearing Hospital.

A FEW days ago I happened to find a GUY'S GAZETTE containing an account of the work of the Special Reserve in training. The author divides the possibilities of medical service into two classes: field work and base hospital work. A factor of intermediate function has, however, become of great importance during the present war—the Clearing Hospital. I am taking advantage of a short period of comparative rest to scribble a few notes on the subject of our work.

At the outset one must point out that anything like scientific observation has been impossible when material has been plentiful, for the work involved in treatment alone has exercised our utmost capacity. One can only claim, therefore, to record a few impressions, and regret in passing that such a wealth of opportunity has been lost to medical and surgical science.

The position of a clearing hospital is, roughly speaking, within sound of guns, but without their range, although we have had a sufficient experience of shelling to allay any craving we may have felt for that excitement to which reference is made in your previous paper. I have met many brave men during the last few months, but none who claim to enjoy the scream of Jack Johnson and his confrères.

The work in which we have been engaged hitherto may be divided very definitely into two periods corresponding to the battles of the Aisne and Yprès. This applies to matters military and medical alike. During the Aisne battle bullet wounds were quite exceptional, and tetanus played an important part; from the Yprès area we received an equal number of rifle and shell wounds, and the incidence of tetanus has considerably decreased. Whether the latter fact has been due to the almost universal application of prophylactic serum since the earlier weeks of the war or to a peculiarity of the earth in the Aisne district is undecided, although I have only seen two or three cases of malignant œdema proper (due to B.M.O.). I have seen many cases of a closely allied condition which appear to be due to organisms of the same group. The clinical aspect of these cases is very definite. Within forty-eight hours the patient may be affected beyond hope of recovery. The tissues around the wound are emphysematous, though there appears to be less gas formation than in cases of B.M.O. infection. The pulse is extremely feeble, a very constant factor. Mentality is unimpaired almost to the last, although the patient may live for two or three days after the onset of symptoms. This fact renders the cases very distressing to the practically powerless observer. Apparently the infection is conveyed actually at the time of the wound from contact with the highly cultivated soil of the trenches which is carried in with

fragments of clothing; it is, therefore, distinct from "hospital gangrene," although one has been forcibly reminded of conditions of fifty years ago. One now understands the origin of the term "laudable pus."

Other cases of gangrene are milder, and due to mechanical factors, pure and simple, or to the combined effects of trauma and infection with organisms of a less virulent type, possibly saprophytic. Some of these are locally emphysematous on account of the activity of B. aerogenes capsulatus, etc., but as the condition does not tend to spread under suitable treatment, and the effects are purely local, they are distinct from the former class.

A comparatively common type of gangrene of the leg is due to wounds of the popliteal artery. Frost bite is becoming responsible for an increasing number of cases of gangrene of the foot, and promises to play a serious part in winter warfare.

Medical cases are comparatively few; there is little typhoid and less pneumonia; the proportion of sick to wounded is so far considerably smaller than has been the case in previous campaigns.

We have many cases for operation: chiefly amputations and head cases. The most satisfactory type of case, from the surgeons' point of view, is provided by the depressed "gutter" fracture of the skull, in which good results follow operations. More extensive brain wounds fare badly, as a rule; one can only decompress, locally or by the subtemporal method. Although we give up as hopeless no head case that is not actually moribund, our labours are rarely rewarded by success. One unsatisfactory feature of clearing hospital work is due to the necessity of evacuating cases as soon as possible; consequently one can only guess as to their ultimate course. Unless definite indications arise we do not operate on abdominal cases, as the risks of laparotomy under the conditions are considered to outweigh the possibility of benefit therefrom. A surprisingly large number of bullet wounds of the abdomen recover under non-operative treatment, at any rate sufficiently far to enable one to send them to the base, where, perhaps, an operation is performed for subphrenic abscess, etc.

The hospital train is an admirably fitted unit; it enables one to remove with comparative safety to a better part of the world cases which would in civil life be rigidly confined to the same bed for weeks or months. It is when the train fails to turn up regularly, as may occur after a change of position, that we become seriously overworked. The vast majority of our cases can be transferred to the train after being re-dressed, although many remain with us for a week or even longer.

On paper, a clearing hospital has 7 medical officers attached, and accommodates 200 patients—no beds. At the present time we have 11 medical officers, a dentist, a bacteriologist, a variable number of Red Cross dressers, and five Sisters (the latter whenever our position is considered reasonably safe, although they much resent the implied objection to risks). Our horses have been discarded, likewise our tents.

We frequently accommodate 600 or 700 patients, who are distributed amongst the various large buildings of the town or village we happen to inhabit at the time. As many as 1,300 passed through our hands in one day during the Ypres engagement. Fortunately the numbers have decreased considerably, and at the present time there are only 50 cases in our wards.

F. COOK.

The Log of the "Glengorm Castle"!

To be whirled suddenly from the entrancing surroundings of "Hickman's Folly," Tabard Street, and other delights; and to be dumped upon the "ocean wave," is an extremely pleasant sensation, even though the change is only to last for a brief period of fourteen days. Such, however, was our good fortune, and I am sure that each one of us at the moment felt the happiest man in the Boro.' As my bedroom door opened on the evening of the 18th October, I could have sworn that it was to allow for the entrance of "Sir Edward," with his eternal "Card for you, sir!" But no, fortune smiles on a few occasionally, and on this occasion it was the cheery visage of ——, who had come to ask me if I would sign on to dress Indian sick and wounded on the good ship *Glengorm Castle*, for a period of fourteen days.

The answer was not long forthcoming, and on Tuesday 20th we four were bowling, at an extremely moderate and sedate rate, on the London, Tilbury and Southend Railway, *en route* for Tilbury Pier.

Arriving there at 10.15 a.m., we were put aboard the *Glengorm Castle* by a tender, and introduced to our P.M.O., Colonel Prall, an old Guy's man, and one who embodied, as regards thorough sportsmanship and consideration for we junior men, all the traditions and associations of the Hospital. We went below and met our shipmates, all of whom were charming, and made us very much at home in a few hours.

12.15 midday.—We have weighed anchor and are dropping down the river.

1.30 p.m.—Passed Chatham, two destroyers lying in the fair way, nothing else of interest to be seen. Spent the afternoon getting stores up and stowed in wards, cut up lint, cyanide gauze and wool until we had "occupation bursæ" on each thumb.

4.30 p.m.—Slack and pipes. Blowing pretty fresh, N.E. wind. Sea roughish. We begin to lift to it, Billy, by a piece of masterly tact—discovers the horrid fact that we can only log a steady 12 knots—help! Our "Skipper" is absolutely one of "the" best. Passed four more torpedo boats on our weather. Things below are still a bit chaotic. We have each been allotted to a Ward under a Colonel, with two orderlies to assist us.

R. has the "Theatre" in addition. Off South Foreland. We swing to adjust compasses 5 p.m.

6.50 p.m.—We are off Dover harbour. Nobody has the faintest idea where we are bound for. Some say Calais, others Havre, others still Boulogne. The place is one mass of white light from search-lights, which were constantly playing on us. We drop one pilot and take on another. During this manœuvre we hear a man shout that we are to go to Boulogne. Just before leaving the harbour a destroyer looms out astern of us going "all out." The search-lights flash upon her dripping sides for one second and she merges into the inky blackness of the open Channel. A really magnificent and impressive sight. I am sure we all thought with one accord, "Those are the fellows who are keeping us at home safe and sound in our beds."

7.45 p.m.—We're off. Where for nobody knows or cares. The ship's officers are wrapt in an impenetrable air of mystery.

10 p.m.—The cloud is broken! We are off Boulogne, the lights of which are twinkling in an enticing manner. Out comes a patrol boat with a small search-light at her bows. A hoarse voice demands in French where we are from and we reply London. We receive orders to anchor till morning.

Colonel J. and B. are detailed to go ashore in the morning to obtain orders and information generally at daybreak! The rest to get up at 7.30 a.m. and "clear for action."

Wednesday, October 21st.—Up 6.30 a.m. Hazy morning. Sea like glass. H. loud in his recriminations of the ship, the earth, crew, the voyage, etc.. anyone would have thought he was unused to getting up at 6.30! (This is meant for sarcasm.) We bath. Beastly cold! Breakfast 8. We noticed there was not much talking done. Somebody left the dispensary "scales" out last night. B. gets it pretty heavily, although he was entirely disinterested!

10 a.m.—We enter Boulogne on the top of the flood. We sight the *Gilbert Castle* with her complement of Thomas's men aboard. At any rate, we are in first! H. and I have a priceless R.A.M.C. private for orderly—Myers by name. He was a veritable encyclopædia for information and always did the right thing. We are surrounded by grunting tugs and launches whose skippers yell at us and at each other alternately in a vile patois savouring of "those who go down to the sea in ships." There are some French T.B.D.'s and submarines in the harbour. I forgot to mention that yesterday off Chatham we saw the *Ophelia*, a vile German mine layer. She was painted exactly like a British hospital ship, and was caught "in the act" by the *Undaunted*. An amusing incident: The P.M.O. has a rather fine telescope—his ewe lamb. R. is constantly borrowing the same, and has now completely disappeared. The P.M.O. who has been unable to look at the last four "specks" on the horizon, is furious. It eventually turns up. We are all posted for "boat and fire drill."

10.45 a.m.—Appalling news. We cannot do anything till to-morrow as the Indians have not yet been in action. No means of getting ashore either. One of our two sterilisers has gone wrong owing to somebody's carelessness! The resistance plate connections have fused, as some bright spark let it go on boiling without any aqua pura at all.

11.8 a.m.—SS. *St. Andrew*, G.W.Ry., outward bound for Southampton full of British wounded. Rain. Good news. Germans driven out of Ostend and Bruges.

1 p.m.—Heavy lunch followed by "masterly inactivity." French submarine passed very close to us, going E ¼N. approximately. Curious shape. Carries two torpedoes on either deck above water line. No work. Try to read up Faraboeuf's "Words of Wisdom" on amputation of the leg! Dismal result. A lot of French fishing-smacks out. Very pretty rig.

4 p.m.—The same submarine came into Basin after having been submerged for over an hour. A spot of sun. Shore looks very pretty. To the north Cape Grisnez with its fine lighthouse, followed all along by a rugged coast line with scattered seaside resorts. Wimereux nearest to us on the north side. A little place with square, white houses, suggestive in bright sunshine of an Algerian town.

5.45 p.m.—There is a notice up to the effect that "*Fire and Boat Drill*" will take place to-morrow at 9.30 a.m. followed by details and instructions. It makes a welcome break after inactivity.

Thursday, October 22nd, 9.30 a.m.—Fire and boat drill. Very amusing.

11.30 a.m.—We enter Boulogne and are berthed in the "Basin Loubet," just above the *Carisbrooke Castle*, a British hospital ship; the latter is taking on wounded as fast as she can go. A big lot of shells are being unpacked on the quayside; they have red crosses to designate their potentiality! More nuts for the Kaiser. A lot of picturesque French infantrymen and sailors about. The latter wear a delightful little cap with a red pom-pom on the top; they call it a berét-marin. I am accused of being a kleptomaniac because I want to possess one for a souvenir.

3.10 p.m.—We are inspected by General MacPherson and his Staff.

4.45 p.m.—We all go ashore and have a walk. Horrid rumours afloat that there are German submarines in the Channel. Nobody knows for certain. We watch an armoured train being built by British bluejackets, who were completely "on their own." They mounted one 4-inch gun in 12 minutes and put up the carriage for another in 7 minutes. Can hear big guns firing from the N.E. over Wimereux, which is, I suppose, about 40 miles from the present firing line.

Friday, October 23rd.—Poor news. The Prussians are attacking along the entire line with fury. 1,000 British wounded are said to have arrived here yesterday night! We sent off a squad of 12 R.A.M.C. men and a corporal to help at the Quai Chanzy

Station. They say the Indian troops have only just gone into action, so we will probably not get any till to-morrow night. The most severe fighting is now going on between Dixmude and La Bassée.

11 a.m.—Went ashore to see the British wounded arrive at the station. Awful and depressing sight. Some terribly maimed. We could actually smell the gangrene in some cases as they got out of the trains and the whole environment reeked. The R.A.M.C. men were very careful and gentle with the wounded and are working incessantly day and night. Most of the "Tommies" were from Lille and looked worn out. They were very dirty and torn and had shaggy beards in many instances. The thing, I think, which struck one most was not the wounds, but the general appearance and expression which conveyed more than anyone can relate or write in words what they had been through. They were a motley crew, all sorts of regiments, from men with the brogue of the Emerald Isle to the most fluent Cockney. We heard of a distressing incident. A father, son, and nephew were all in the same train, wounded, without either being aware of the presence of the other. The father died on the platform. These sort of incidents were comparatively common. The arrangements for the transportation of wounded were excellent. Men are dressed first in the "Field Hospital," this being generally quite close to the firing line, say a mile away. Stretcher bearers are sent out from here to bring in the wounded. I believe that officers in charge of these hospitals have orders not to move to the actual firing line, but the calls are apparently so frequent, and one supposes so urgent, that they neglect the orders, and have consequently to face a heavy fire possibly on more or less open ground. If this is so it certainly accounts for the heavy casualties amongst the commissioned ranks of the R.A.M.C., but at the same time one admires and honours men who do not hesitate to take these risks. From the Field Hospital the wounded are sent to the rear where they are temporarily housed in a Base, generally some village a few miles behind the firing line, and from here they are sent by train to the Base Hospital at the coast.

On arrival the train is unloaded as quickly as possible, and a long fleet of motor ambulances streams constantly from Base Hospital to train and back. Here the wounded are again dressed and rested, and in a varying time of from a few hours to several days are sent aboard the hospital ship and across to Southampton. One of the big "Bases" is situated at Bailleur, and from here wounded are brought by train to Boulogne. The average time which elapses from being wounded to being taken into the Base at Boulogne appears to be from two to three days, which, considering the risks incurred and the numerous difficulties attendant on the transportation of wounded in large numbers, is very reasonable. Nearly every man seems to have had morphia fairly soon after injury, although exceptions will naturally arise, and one will hear people proclaiming how they went for days in a French village without seeing the Red Cross. This is obviously unavoidable.

The troops are having excellent food, in the trenches even, and get the same, officers and men alike. Tobacco is quite plentiful, as the share of those fallen is meted out to the survivors. It is thus possible, and, indeed, probable, that each man gets "dressed" at least twice since being wounded before finally reaching the main Base Hospital. This was certainly the case with most of the Indians, although when a rush occurs the slight cases naturally have to bear the brunt, and may arrive as they left the Field Hospital. All the "dressings" from the front were excellently applied, and one never saw a loose bandage. Cyanide gauze with iodoform powder seems to be the order of the day with ordinary white wool. Splints are more often than not improvised, but are always practical and answer their function efficiently, which is, after all, the main thing. Many wounded arrive with a label attached to the lapel of their tunics giving details of their wounds, the date, and whether or not they have had anti-tetanic serum. This latter was always extremely useful to know, but unfortunately was frequently omitted, and the men who had had a hypodermic of morphia were generally under the impression that they had been given serum. The Indian troops dread the needle or "pishgari," as they call it, and will call loudly for the "parni," or "water-variety" of morphia (liq. morph. hydrochlor.).

ANAS BOSCHAS.

(To be continued.)

Vignettes from France.

II.

To say that we were tired hardly expresses our feelings at that time; for, with our utter physical weariness we were dispirited, although doggedness had not given way to despair.

For nearly a fortnight we had retired, not understanding what was happening, hardly knowing where we were going, but marching day and night with the restless energy of some caged animal. Two days ago we had left behind us the Forts of Paris, whose shelter we had not welcomed, not knowing of Maubeuge or Namur, and were marching due east. Early in the morning of the following day we encountered small bodies of Uhlans whom we drove before us, with small loss to ourselves, and, after a morning of disjointed fighting with these, the ambulances were able to advance and collect the wounded. There they were, six of them, lying in the shelter of their respective coats hung across their bent lances, dotted over

the field of stubble where our own lances and shrapnel had caught them. Six of them, remarkably and unintellectually similar, all fat and flabby, with hair beginning to grow again on their shaven heads and with their chins in a similar condition.

These, then, were some of the "Apostles of Frightfulness" of which we had heard so much. It is hard to describe the joy with which we saw them. For a fortnight we had been retiring, and for most of us it was the first time we had seen a German. We dressed their wounds and put them into an ambulance, and, after sending them to the rear, we went on slowly, halting while the cavalry cleared the woods in front of us and made certain it would be safe to proceed.

Finally, at about mid-day we came to a stop and parked in a field, where we had lunch. We stayed there till 4 p.m. when we received orders to proceed to a village eight miles away. We arrived there over some fields, and, at the side of the road, found the Uhlans' bivouac of the previous night. It was in a filthy mess; straw and bottles were littered all over the camp—an orchard—and the ashes of the small trench fires were scattered round them, with articles of equipment in various places to put a finishing touch on the general appearance of untidiness. Everything suggested that the Germans had left in haste. They had even forgotten some bottles of sterilised catgut, which we picked up and used; also some sterile gauze in tins, but these had been opened, so we left them lying where they were.

We took our ambulance out of the orchard into the village, where we parked for the night in a farmyard. After the horses had been watered and fed we went along to Brigade Headquarters to get our orders for the next day. Somehow there was a subtle difference in the air, everybody was more cheerful, and the men were moving about their duties in a more light-hearted spirit than hitherto. The road along which we were to move next day stretched straight in front of us. In the gathering dusk we could see it for a mile ahead, hemmed in by trees, until it disappeared from sight over the crest of a hill. Suddenly the meaning of the unwonted cheerfulness flashed upon us. The sun had set, but there was still an afterglow in the west, which lay on the left of the road along which we were to move before morning.

Yes, sunset was on the left of our road; we were not dreaming. The fact that we had to wait up for supplies was now of small consequence; for the first time since we had left Belgian soil life seemed bearable, even pleasant. We had started to advance!

H. C. R.

(To be continued.)

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

DEAR SIR,—The case of Acute Yellow Atrophy so excellently reported by Mr. R. Curle, is very interesting. This disease is rare, I believe, in England, and one feels that every case should be reported. The causes are few as far as the text-books go, pregnancy, being one, in this case that is out of the question, but there is one disease I have not often seen mentioned, that is Exopthalmic Gôitre. I have seen one case of such, and I am more than anxious to know what condition the thyroid was in, or if any such symptoms were recognised during life and anything post-mortem. It is curious that urea existed, as truly the reporter says, the urine did not follow the disease, perhaps Mr. Curle would not mind filling the thyroid point.—Yours,

T. B. JUDGE BALDWIN.

December 26th, 1914.

DEAR MR. EDITOR.—Cheer up! Cheer up! When you launch lightly on "lability" I'm beat; but when you talk of pessimism I'm ready to confront you. Why pessimism? Is it because the horrors of war have devilled themselves into your splanchnics—or other part of your sympathetic system? Never has an Englishman had cause to lift his head more highly than at present. Honour—bravery—sympathy—justice—all combined. What matter so long as the tyrant is laid low! We did not create the tyrant; but having been created, let us combine to crush him with no note of pessimism.

As an old Guy's man who reads his GAZETTE, may it be permissible to air my views.

Firstly.—Honour and credit to the Governors who wish to carry on as usual. *Theoretically*, Guy's loses kudos and the patriotic pleasure of tending wounded heroes. *Practically*, Guy's does more stolid work—for from (unfortunately) experience in past years, a base hospital, such as Guy's would be, will not receive the most urgent cases.

A fracture needing plating will find his way to Guy's for a certainty, and so will other cases who require especial treatment. Why, then, wish to fill the wards with convalescents who would never be admitted in peace? The article signed "E. S. T." of October 24th proves this argument.

Secondly,—Let the world know that Guy's tends her poor as in the past, and Guy's will never have cause to regret it.

Finally, sir, let me assure you that we Colonials fully realise the sorrow and distress caused to our mother land by a G.P.I. Kaiser, but we also realise that you are at least united in a common cause. Lest us ask, therefore, that you spare a moment to think of us in a country with rebellion and civil war upon us. Have we any cause to be pessimistic? Well, let England rest content that although we cannot help her we can at least boast that every Englishman here is loyal and that there are more than enough Dutchmen ready to uphold their honour and blot out their rebel brethren and traitors. When once we finish with rebellion, then comes the crux of German South West Africa, surely the most terrible country in the world. The troops to fight there are mostly English and the troops quelling the rebellion are mostly Dutch.

Tell those Cape Colonials at Guy's that they have no cause to be ashamed of the manner in which the Loyalists of both European races are facing the music.

So far I have only found four Guy's men serving with the troops—Colonel W. T. F. Davies (O.C. 2nd I.L.H.), H. A. Moffat (rank unknown, but think in charge base hospital, Upirgton), Capt. H. R. Mullins (M.O. 1st I.L.H.), and Tpr. A. G, Forrester (No. 80, Legion of Frontiersmen). The last named was a dental student about four years ago.

By a most extraordinary coincidence, the two "doctors" (C. E. Lyertwood of Leeds, and W. T. F. Davies of Guy's) of the I.L.H. in the siege of Ladysmith are now the two Colonels in charge of the 1st and 2nd I.L.H., a fact to my mind worth recording.

I trust you will pardon the length of this letter, some of which is merely "gabbling."—Yours truly,

R. C. MULLINS.

The Grotto,
Grahamstown,
Nov. 24th, 1914.

DEAR MR. EDITOR,—I came over here three weeks ago in response to an urgent request for a Radiographer. When I left I understood I was to be attached to Boulogne, but was at once sent here. So far I have not had too much to do, but this is mainly due to the fact that our last batch of "wounded" were knocked out by frozen feet, none of them, however, at all severe, but apparently very painful, especially at night. If this batch had been really wounded, I should have had my hands full.

I have seen a great many interesting cases, and later on will send you a few radiograms of the most interesting ones, if you care to have them. It is astounding the way bullets, etc., travel.

We have a good Gaiffe installation here, but until the last few days have not been able to screen, so that some bullets have been very elusive. Yesterday I ran to earth a shrapnel ball in the left axilla, entrance wound above right clavicle, with clinical lung signs on right and pleuritic pain at right base, but no pain or lung signs on left. In another case I found two balls in a man out of whom seven had already been extracted. One had practically removed the articular head of the humerus.

My short experience here makes me think that by far the worst wounds and injuries to bone are caused by bullets at short range. They seem to me to do far more damage than shrapnel balls, or fragments of shrapnel casing (which are usually comparatively small). Pieces of bone are often completely missing after rifle wounds, and the splintering is appalling. Needless to say they are practically all septic on admission.

A French Captain here has 28 wounds in one leg from splinters of shrapnel. Altogether he must have over 40, but none of them serious. The man next to him was killed by the same shell.

I have taken the opportunity to see as much of Paris as is to be seen at this unusual time, and have also visited some of the hospitals, particularly the Radiographic Departments. The best of these that I have seen is at the Val de Grâce, where the installation is particularly good. All radiography there is done with a Gaiffe apparatus with revolving commutator (much like the Snook apparatus) working at 20 milliampères or more. An aircooled tube is used, air being forced through a rubber tube by a fan placed outside the room. The target is red-hot at the end of each exposure, but rapidly cools again. A separate room is used for fluoroscopy with a less powerful installation.

We are expecting a portable apparatus for use at the bedside and for taking to those hospitals not equipped. This hospital is splendidly fitted up and well staffed. So far I have not met any one from Guy's, except that on board I came across Stanley Cock's brother, who was at Guy's for a time. I think he is now in R.F.A. Unfortunately I am only able to stop out here for a short time, and by the time you get this I shall probably be home again. Best Christmas wishes to all at Guy's.

A. ATKINS GREENWOOD.

Auxiliary Hospital No. 1,
(Hotel Astoria)
1, Rue de Presbourg,
December 18th, 1914.

DEAR MR. EDITOR,—Valuable experience is gained from "running the front." Might I venture to make a suggestion, which, if carried out, would enable dressers to derive even more benefit from it. At present a diagnosis is made on the back of all out-patients' cards; whether it is the right one or a "hopeless brick" the dresser never knows. Could not all cards be returned to the respective dressers with the correct diagnoses written on them? It would mean very little extra trouble on the part of members of the Staff or Out-Patient Officers.—Yours, etc.,

D. M. WHITCOMBE.

Nursing News.

MATRON'S OFFICE.

From the Present Hospital and Institution Nursing Staff and a few interested friends a small Christmas gift, consisting of a card with appropriate greetings, decorated with the Guy's crest and a view of the colonnade, and four handkerchiefs (marked with the owner's name), was despatched to 114 Guy's nurses working abroad or on hospital ships. Two who had been invalided home received theirs also. Had it been possible we should like to have included all Guy's nurses on war service in England also.

During the past few days many letters have been received by Matron and Sister at the Institution acknowledging the safe receipt of the gift, and thoroughly appreciating the small token of remembrance from all friends at Guy's, letters telling of the many thoughts directed towards the Hospital and its Christmas festivities, and especially towards the writers' own wards.

Several more of our correspondents have been sent on to Clearing Hospitals. No doubt our readers know that the employment of women as nurses in these places is sanctioned by the War Office for the first time. Tetanus is not mentioned in these letters, but chiefly the terrible effects of frost and exposure to bitter wintry weather. Deaths from shock and gangrene are the result.

Nurse Broome, writing from a chateau not far from the firing line, tells of the ambulance going out for ten wounded soldiers. Three died *en route*, one in the theatre from shock, and the fifth that night. All had been hit by a shell.

Nurse Ames writes from a Clearing Hospital:—"We are all very busy here, and the wet weather is dreadful for the men. It seems incongruous to think of festivities; there is absolutely nothing to remind one of Christmas, but perhaps some good will come out of it all."

The army kit includes a flat iron, and in reply to anxious inquiries as to the result of efforts founded on the aforesaid iron, an oil stove, and a canvas bucket, Nurse Ames writes:—"I am glad to say I have not had to use mine much. Water here is of great value, most difficult to get. We all wash our hands in the same water, wash up in it, and then use it for many purposes before it is thrown away.

"You must not be surprised at anything we do when we get back. The grey uniform is getting somewhat tired, and has quite changed colour, but we who wear it are very fit, and the hard work seems to suit us."

The news is good from Nurses A. M. Ward, Carpenter, and Blyth at the British Red Cross Huts at Netley, where both British and Indian Soldiers are taken. Post card views show the huts to be comfortably equipped, boasting of doctor's tables and plants. "Out in the open," we are told, "the mud is considerable, and of depth and quality not to be surpassed."

Nurses Harden and Horton are at No. 2 General Hospital, Chelsea, and are pleased to be working for Guy's men with military title and attire.

It is reported that the charm of manner and courtesy of a certain Physician and Surgeon, who only lately retired from active service at Guy's, is such as to be winning allegiance from members of other nursing schools.

It may be mentioned that the boarding-out system has found favour with several, even though it includes a 6.30 a.m. breakfast.

This week two more Guy's nurses leave London for work abroad under the auspices of the War Office:—Miss Marie Roussiano and Miss Orchard, who have had experience in nursing on the Continent since leaving Guy's in 1911.

Appointments.

Medical School Appointments.

JANUARY–MARCH, 1915.

Clinical Assistants in Surgical Wards.—Messrs. D. H. A. Galbraith (Sir W. A. Lane); A. H. Taymour (Sir A. Fripp).

Dressers and Clerks in Special Departments:—

Throat and Ear, Genito-Urinary, and Children.—Messrs. G. Noott, J. G. Jones.

Throat and Ear, Skin, and Orthopædic.—Mr. A. W. Cocking.

Eye and Nervous System.—Messrs. A. Traill (Mr. Eason); W. D. Newland (Mr. Ormond).

Obstetric Dressers and Externs.—Messrs. R. Hirsch, K. N. Purkis, E. M. Litchfield, L. H. B. Evans, A. G.

East (Mr. G. B. Smith); V. E. Lloyd, E. S. Bowes, E. Biddle, F. A. Knott, A. D. Marston (Mr. Chapple).

Medical Ward Clerks and Post-mortem Clerks.—Messrs. *E. N. Glover, K. M. Woodruff, R. H. C. Pryn (Dr. Hale White); *H. Wacher, W. B. Buer, M. Pearson (Dr. Shaw); *D. V. Halstead, R. L. Portway (Dr. Fawcett); *G. E. L. Simons, W. J. Vance, H. J. Bensted (Dr. Beddard).

*With duties in Out-Patients and charge of Assistant Physicians' beds.

Medical Ward Clerks.—A. W. A. Davies, J. W. H. Grice, T. L. Heath, J. T. T. Forbes, R. S. Millar, F. W. Heckels, H. E. Bamber, W. Burridge, J. M. H. Campbell, C. L. Odam, H. S. Vertue, R. Aspinall-Stivala, J. F. Carter-Braine (Dec.-Jan.), S. Vidot.

Surgeons' Dressers.—Messrs. M. B. M. Tweed, T. E. Micklem, J. S. Ellis (Sir W. A. Lane); H. M. Gray, W. H. A. Pratt (Mr. Dunn); D. M. P. Whitcombe, G. E. Kidman (Sir A. Fripp); P. G. McEvedy, I. R. R. Brogden, F. N. Sidebotham (Mr. Steward).

Assistant Surgeons' Dressers.—Messrs. R. R. Traill, B. E. Jerwood (Mr. Fagge); M. C. Joynt, E. S. Philips, A. Roca (Mr. Rowlands); H. I. Sterne-Howitt, P. D. Chapman (Mr. Turner); L. S. Gathergood, I. Tewfik (Mr. Hughes).

Surgical Ward Clerks.—Messrs. L. A. B. Moore.

Student Demonstrator of Microscopical Pathology.—Mr. R. A. Holmes.

Naval.

To be Surg. Probationers: C. T. Helsham, W. A. Turner.

Surg. Probationer J. A M. Alcock to the *St. George*, additional for the *Itchen*.

Royal Army Medical Corps.

To be temporary Lieutenant-Colonel: Capt. Sir W. Arbuthnot Lane, Bart.

2nd Wessex Field Ambulance.—To be Lieutenant: H. N. Collier.

3rd Wessex Field Ambulance.—To be Lieutenant: Frederick Tooth.

1st Home Counties Field Ambulance.—Capt. A. T. Falwasser to be Major (temporary).

To be temporary Lieutenants: C. H. Mills, H. C. Godding.

4th London Field Ambulance.—Capt. T. B. Layton to be Major (temporary).

1st Southern General Hospital.—P. P. Cole to be Lieutenant (T).

2nd London Clearing Hospital.—E. S. Taylor to be Lieutenant (T).

Temporary Captain R. Davies-Colley, F.R.C.S., to be Major.

3rd London (City of London) Field Ambulance.—Major John A. Masters, from attached to other than medical units, to be Lieutenant-Colonel (temporary).

Attached to other than medical units.

Capt. H. V. Leigh, M.B., B.S., M.R.C.S., 5th Welsh Regiment.

N. E. Fasken to be 2nd Lieutenant, Royal Marine Artillery.

L. B. Stringer to be Lieutenant.

Douglas A. Bevis to be 2nd Lieutenant, Hants (Fortress) Royal Engineers (T.F.).

Sidney W. Bevis, 2nd Lieutenant, Royal Field Artillery, 106th Brigade.

R. V. Knight, 2nd Lieutenant, 8th Batt. City of London Regiment (P.O. Rifles).

Papers by Guy's Men.

H. Charles Cameron, M.D.: The cause of hernia in infants.—*British Medical Journal*, December 19th, 1914.

Arthur F. Hertz, M.D. Oxon, M.A., M.R C.P.: X-ray, diagnosis of gastro intestinal conditions, with special reference to appendicitis.—*Archives of Rontgen Ray*, December, 1914.

J. E. L. Johnston, M.B., B.S.: Yellow Fever.—*British Medical Journal*, December 19th, 1914.

H. C. Mann, M.D., M.R.C.P.: The feeding of babies with undiluted milk.—*Clinical Journal*, December 16th, 1914.

F. Newland-Pedley, F.R.C.S., L.D.S.: Our Army's teeth.—*Lancet*, December 19th, 1914.

J. G. Saner, M.C., F.R.C.S.: Discussion on the localisation of foreign bodies (including bullets, &c.) by means of X-rays.—*Proc. Roy. Soc. Med., Elect. Ther. Sect.*, November, 1914.

A. W. Sheen, M.S., F.R.C.S.: Colectomy for intestinal stasis.—*British Medical Journal*, December 26th, 1914.
Deputy Surgeon-General A. Gascoigne Wildey, R.N.: Iodine as an antiseptic in joint injuries.—*Ibid*, December 19th, 1914.

Death.

TURNER.—On Dec. 9th, at "Holmwood," Bournemouth, Henry Gunton Turner, M.R.C.S., aged 68 years.

W. E. T.

GUY'S HOSPITAL GAZETTE.

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Passim.

WE regret to hear that Richard Bredin, M.D., died at Orotova, Teneriffe, on January 9th, in his 58th year. Entering Guy's in 1878, he qualified M.R.C.S. Eng. in 1880, and took the London M.B. Degree in 1881, with First Class Honours in Medicine and Second Class Honours in Obstetric Medicine. Dr. Bredin was much attached to Guy's, for during the time he was practicing successfully at Valparaiso, he founded the "Bredin Prize," which was for many years competed for at Guy's. Dr. Hale White writes:—

> "He had wretched health when he was a student so that directly he passed his M.B. he left Guy's. For many years he practised in Valparaiso, where he occupied a fine position, for he was a man of great character and an extremely able physician with remarkable clinical instinct. I have heard him described as the one physician down the whole of the Western Coast of South America. About twelve years ago he retired, living for a short time in England, and then, on account of his health, in Teneriffe. He was an invalid all his life, and the way in which he fought against ill-health and always kept cheerful, inspired the admiration of all who knew him, indeed in this respect he was not unlike R. L. Stevenson."

FEES IN CORONERS' COURTS.

A protest was made by Dr. Claud Hamilton Gould, the House Surgeon at Guy's Hospital, in the Southwark Coroner's Court yesterday. After giving evidence in a burning fatality inquiry he said: I should like to make a protest. When I was 21 I had about £2,000, which I invested in medicine. I am now 30, and I am practically penniless. I was here at three o'clock, and now it is five minutes to five. By coming here I have lost five guineas. By coming here I don't get a penny.

The Coroner (Dr. Waldo): I am very sorry. We have had a long anthrax case, and the previous case was longer than I anticipated. I have every sympathy with you. I cannot give you a penny. Doctors in hospitals when patients die don't get fees. I have suggested that they should. You are paid in all other courts except coroners'. If you had been any other doctor but a hospital doctor you would have received a guinea.

A Juror: It is not right.

Dr. Gould: I am working sixteen hours a day.

The Coroner: You have my sympathy entirely, but how can I help you?

A Juror: Cannot we make some recommendation?

The Coroner: On your suggestion I could write to the Home Office.

The jury said perhaps the best course would be for the coroner to write to the Home Office himself.

The coroner said he would do so willingly. It might be that by constantly asking they would get something.

Daily Telegraph, January 5th, 1915.

THE residents in all voluntary hospitals will congratulate Mr. C. H. Gould on his spirited protest against the monstrous anomaly which prevents them from receiving fees for their evidence at inquests and for the performance of post-mortems ordered by coroners on patients who die in hospital. Dr. Waldo has already sent in a recommendation to the Home Office, and we hope this injustice will be attended to promptly. We believe that it owes its inception to a medical man. Apart from the question of guineas, attendance at inquests is sometimes very inconvenient. Last Saturday our Senior Obstetric Resident had to abandon

a partridge drive in order to attend an inquest at Rotherhithe. On Friday evening he journeyed to the mortuary to perform the post-mortem, which proved to be very interesting, and my sporting friend quite forgot the birds.

The subject was an eight months' male child weighing 4lbs. 1 ounce, which had lived for six days after birth. Just before death it was seized with convulsions and puked up blood. At the post-mortem, the right lateral ventricle of the brain was full of dark ante-mortem blood clot, and the left lateral ventricle contained blood-stained fluid. The third and fourth ventricles were full of blood and clot was adherent to the cerebellum and floor of the fourth ventricle. The cavities of the heart contained blood-clot; the lungs were not fully expanded, the left lower lobe was airless and sank in water. The liver was congested and had the typical nutmeg appearance; the kidneys were slightly congested and blood and blood-stained mucus were found in the stomach. The intestines were normal; the bladder was very distended, and the attendant remarked that whenever he saw a full bladder the cause of death was usually cerebral.

"THEY ALSO SERVE."

A Guy's Hospital doctor stated at an inquest at Southwark yesterday that many members of the medical staff had joined the colours, and a great amount of extra work had to be done by those who remained.

Dr. Waldo: Many people complain of having to work long hours, but many doctors work twelve, eighteen, and even twenty-four hours at a stretch without complaining. I suppose you are handsomely paid at Guy's hospital for your work?

The doctor: I am afraid not.

May I ask what is your salary?—Nothing at all.

You are doing the work of four men, I believe, yet you say you get nothing for it?—Not a penny.

We do not think that House Officers should be paid. Those who hold these appointments gain very valuable experience in return for the work which they undertake quite voluntarily. Our duty to the Hospital differs very materially from our obligations to the State, in that the latter are compulsory, and therefore should receive tangible recognition. The question of medical certificates is a very complex one. It is only common justice that certificates should be given to hospital patients, and thereby the state or employer get valuable information for which they could well afford to pay. We must be prepared to make this small sacrifice otherwise the position of the sick or injured employee would become intolerable.

PAST and present students and pupils of the Dental School will hear with great regret that Mr. W. T. Flint, the Senior Mechanic in the Pupils' Laboratory, has had to resign his appointment through ill-health.

During the past ten years many students and pupils have received from him valuable advice, and we tender to him our best thanks for all that he has done, and wish him the best of good luck and health in his new sphere of work. As some of the students have expressed a wish to present in a concrete form some small token of their appreciation, a fund has been started for this purpose.

Contributions, however small, from both past and present students, will be gratefully received by the Secretary of the Dental Society, Mr. W. J. Rousseau Viljoen, at the Hospital.

The Annual Dinner of the Guy's Hospital Dental Society will not be held this year. We hear rumours, however, that the President intends to give a quiet dinner to the Officers of the Society, and we hope to be there in the capacity of GAZETTE reporter.

As is customary at the beginning of the year, statistics from the various departments in the Hospital are published in this GAZETTE.

Guy's men will be interested to know that electro-plating shops has been provided during the year in the Works Department.

The donations received from patients in the wards show an increase of £110 13s. 11d. on the corresponding figures for 1913. The collection of £66 15s. in Stephen Ward shows that our wounded officers and their friends also appreciate the efforts which the Hospital is willingly making on their behalf.

WE hear that, owing to his Hospital duties, Mr. E. W. H. Shenton, our senior Radiographer, was unable to accept an offer of the rank of Major in the Army as an X-Ray specialist to the Military Hospitals' over seas.

WITH regard to Mr. Whitcombe's letter in the last issue, we suggest that dressers' who wish the Out-Patient's cards to be returned

to them should make a distinctive mark to that effect on the cards. With the present pressure of work it is quite impossible to return all the cards, and no useful purpose would be served by so doing.

MAY we call your attention to a Course of Three Lectures on War and Disease, given by Dr. F. M. Sandwith at the Royal Society of Arts, John Street, Adelphi. The first lecture, dealing with the Continental Wars of the Nineteenth Century, was given on January 15th. The others, dealing with the South African and Russo-Japanese Campaigns, and the Great European War, will be delivered on the 22nd and 29th of January, at 5.15 p.m.

ON the 30th December one of the House Surgeons took the children in his wards to the pantomine at the Elephant and Castle Theatre. The loud cheering which heralded the return of the children to the Hospital showed their appreciation of this unexpected treat.

On Friday the 8th January, 50 children from Mr. Trethowan's Out-Patients' were entertained to a tea arranged by Sister Out-Patients' and Nurse Strutt. The Matron was present and gave toys and sweets to every child. The children were very happy, although their movements were seriously handicapped by spinal jackets and plaster splints.

ABOUT a week ago a little girl was sitting in the O.P.D. hall, and was asked by Nurse why she was waiting. "I want my name down for the Christmas Tree," the child replied. "But that is all over," Nurse said. "I want it down for next year," the child said.

A LITTLE girl attending the Orthopædic Department brought a doll to give to Nurse. Mr. Trethowen said, "Oh! I call that bribery and corruption." "'Taint," said the child, "It's a dollie."

BY a careless oversight we omitted to mention in our last issue that Mr. H. N. Eccles journeyed all the way from Plymouth on Christmas morning in order to make his fifth consecutive appearance in the Niggers! Such keenness is to be appreciated in these strenuous times.

DEATH FROM ANTHRAX.

MYSTERY OF THE SOURCE OF INFECTION.

At Southwark Coroner's Court yesterday Dr. Waldo concluded the inquest on the body of Charles Farrant, 46, a butcher's Manager of Mitcham, who died in Guy's Hospital on December 17. Farrant was employed by the Home and Colonial Meat Stores and Managed the shop at the Fair Green, Mitcham. At the previous hearing the Coroner said that Farrant was believed to have contracted anthrax. He had been handling frozen rabbits from New Zealand.

Walter Curtis Martin, butcher, said that he managed his father's shop at the Fair Green, Mitcham. He sometimes bought rabbits in London and sometimes in Croydon. The rabbits came from Australia and New Zealand. On December 7 he bought some beef from Church Street, Croydon, and some from London. When the witness was visiting Farrant he heard that there was a man named Penn suffering from anthrax in the Croydon hospital, and the witness became apprehensive. The witness had had a pimple on his neck something like Farrant's. It was excised and two injections were made. He was still feeling the effects of the operation.

Dr. Legge, His Majesty's Chief Medical Inspector of Factories and Workshops, said that anthrax was not a disease compulsorily notifiable, but two years ago the Local Government Board issued a memorandum recommending local authorities to add anthrax to the diseases which were so notifiable. Death was due to anthrax, which frequently passed unrecognized. It might never be known that an anthrax-infected carcase had been disposed of, and a person consuming anthrax-infected meat did not necessarily die or suffer. The germ was killed by the cooking of the meat. Cases of intestinal anthrax from consumption of infected meat were rare.

The Coroner read a letter from the High Commissioner of New Zealand, stating that no case of anthrax had been found in the colony for a number of years. In no case had anthrax occurred in New Zealand rabbits.

Dr. Robert Clarke, Medical Officer of Health for Croydon, said that he could not trace Penn's death. Nor could he say how Farrant became infected.

The Coroner, in summing up, said he thought Messrs. Armour had taken every precaution.

The jury returned a verdict that Farrant died from external anthrax, but that there was nothing to show how it was contracted. They recommended that anthrax should be added to the list of compulsorily notifiable diseases and that all deaths from it should be notified to the coroner of the district in which they occurred.

Daily Telegragh

Obituary.

THOMAS BRYANT, F.R.C.S.

Senior Consulting Surgeon to Guy's Hospital; Sergeant Surgeon to H.M. Queen Victoria: Surgeon-in-Ordinary to H.M. King Edward VII.

Died December 31st, 1914, in his 86th year.

Thomas Bryant, our veteran, is dead, and we, the younger generation of Guy's men, whose only knowledge of him may be due to the splint and triangle which bear his name, now recognise how much surgery owes to a career which reached great eminence, but, owing to disastrous financial undertakings, ended in a comparative obscurity which was ill deserved. The fruits of his originality of mind, his authorship and skill as a teacher are not dead. We cannot ourselves do justice to the memory of a great man who retired from active association with Guy's before we were born. Something more than a mere tabulation of the recorded events in his life are required for a vivid pen picture. We are told that he was a man of very fine presence, but had no recreations apart from his work. Vanity sometimes prevented him from openly confessing his ignorance. Going round the wards, an ophthalmoscope, an instrument with which he was unacquainted, was given to him. Holding it in an obviously impossible way, however, he claimed to see a large red fundus. A famous mistake occurred in the first edition of "Principles and Practice of Surgery," in which cotton wool fresh from the *back of a sheep* was recommended as a dressing.

In 1893 an appreciation which does more justice to his memory than any words of those who have never seen Mr. Bryant in life can accomplish, appeared in the GAZETTE:—

MR. BRYANT.

Punctually at the appointed hour did Mr. Bryant's carriage always pull up at the Hospital entrance; so punctually indeed, that, bearing in mind the variations of vehicular "stasis" between Grosvenor Street and the Borough, one feels that not a little credit was due to the expertness of his coachman.

On entering the colonnade, there was the genial greeting for his dressers, a hasty inquiry as to the welfare of a critical case, and then, on operation days, the invariable question as to "whether everything was ready in the theatre."

Careful to be in time, and punctillious in exercising his prerogative as senior surgeon, Mr. Bryant would have been ill-pleased with any dresser whose laxity had allowed a junior to be first in the operating theatre. When not himself operating, he was frequently present as a spectator—a *rôle* in which he still sometimes appears—so anxious is he to add to his already vast experience.

Mr. Bryant is *par excellence* practical; he has probably little sympathy with the order of mind which loves such questions as: "The possibility of the existence of knots in a four dimension space?" rather would he have been at one with the Highland laird whose dying words to his son were: "Jock, when ye hae naething else to do, ye may be aye sticking in a tree; it will be growing. Jock, when ye're sleeping." It was his excellent practical teaching which caused such considerable numbers of students to accompany him round his wards, even before he possessed the alluring qualification of being an "Examiner at the College." Probably, too, it was his clinical soundness, as well as a certain originality of method, which caused him to be a centre of attraction to the inquiring foreigner—and especially to the American. The latter confessedly yielded to an admiration for the author of what he rightly considered one of the best treatises on the "Principles and Practice of Surgery;" was he also, perchance, captivated by certain *Ciceronian* qualities recalling a prominent fellow-countryman?

The reference to the "Principles and Practice," reminds one that great surgical writers, like other authors, may enjoy the appreciation of their own works. Abernethy earned the sobriquet of "Dr. My-Book," by his habit of recommending his patients to read his "Surgical Observations."

To return to the wards, "even during the height of the spray and gauze fashion," Mr. Bryant's favourite method of treating wounds was (as it still is) to wash and irrigate them with sherry-coloured iodine lotion, and dress them with lint soaked in terebene and oil; he is exceptional in never having been a "slave of the spray."

Much liked and admired by his subordinates, Mr. Bryant was held in high estimation by his patients. His influence was due, not to the dazzling brilliancy of a Moxon, nor to the Napoleonic impressiveness of a Gull, but to a charm of presence and manner, added to a happy facility for making prominent the hopeful possibilities of any particular individual. It is told how the unfortunate victim of an accident—with an irreparably damaged leg, and in a woeful state of despair—was suddenly lifted out of his slough of despond by the cheery admonition: "Come, come, my good fellow, cheer up, you'll be walking about in a few weeks!" The timely prophecy doubtless assisted its own fulfilment, and in due time he was walking about—the injured limb replaced by a *wooden* one.

An atmosphere of happiness filled Mr. Bryant's wards after his visit. The *wish* of every sufferer to be improved is innate. The paternal potentiality of the wish is proverbial; in this case the touch of the surgeon sufficed to make the thought—nay, the fact—of being better spring, Pallas-like, to life. It was the effect without the paraphernalia of "suggestion."

It is known to the writer that a patient of another surgeon went out, uncured, in order to be re-admitted under Mr. Bryant; when recognised, she stated that she had been completely satisfied with the skill and kindness of her former surgeon; she had simply been captivated by the happiness and hopefulness inspired in Mr. Bryant's own patients.

Besides his work on the "Principles and Practice of Surgery," Mr. Bryant is the author of numerous contributions to Surgical literature; one of the earliest is a paper in the Hospital Reports for 1856, on "Hernia, with an analysis of 126 fatal cases." He was one of the early advocates of ovariotomy. In his work on that subject, published in 1856, he found it necessary to devote a chapter to the question, "Is ovariotomy a justifiable operation?" and we have heard him say that at one period the opinion of his colleagues was so strongly to the contrary, that they declined to be present during his performance of the operation. We believe that this was not the only instance of opposition offered to Mr. Bryant in his career by some of his colleagues.

Mr. Bryant entered as a student at Guy's in 1846—the entries for that year numbering sixty-one; he was dresser to Mr. Key in 1848, and became doubly qualified in 1849; after acting as surgical registrar, he was, in 1857, elected assistant surgeon, in the place of Mr. T. Callaway, junior, who, we learn from the "History of Guy's," resigned his appointment in order to go out to the Indian Mutiny, which broke out in that year. In 1871, on the resignation of Mr. Birkett, he became full surgeon, a position he filled until his translation to the Consulting Staff in 1888.

He has been three times President of the Royal College of Surgeons of England, viz., 1890, 1891 and 1892; a member of the Council since 1880, and a member of the Court of Examiners since 1882; he has been Hunterian Professor of Pathology, Hunterian Orator, and Bradshaw Lecturer.

His honours are the fruits of legitimate conquest, and we wish him a long life to enjoy, and, if possible, add to them.

Mr. Charters Symonds, Consulting Surgeon to Guy's Hospital, writes the following tribute to his late colleague:—

Bryant was a rapid and dexterous operator. From the manner in which he carried out his operations, and from the remarks with which he explained what he proposed to do, it was obvious to all that he had carefully thought out his plans. He was decided and even bold in his incisions, and nothing was finer than the rapidity and yet smoothness with which he would remove a thigh by transfixion. In the ligature of the larger arteries he had, like most men of his time, a wide experience, and his success was probably better than the average. He was a neat and accurate dissector, and thus injured few structures on his way to the vessel. Ever striving for a primary union as the one security against secondary hæmorrhage, he invariably twisted all the large vessels in amputations. In the effort to dispense with the use of a ligature he experimented with the compressor in the case of the superficial femoral. Mr. Bryant was, in operative surgery at any rate, always open to make trial of new methods, when after careful consideration he considered them to be sound. He was no doubt in his day and for several years amongst the three or four leading operating surgeons in London.

As a teacher Mr. Bryant was stimulating and encouraging. He took pains to lead the students through the difficulties of the case, and always insisted on a diagnosis being made. To the senior men he would give suggestions for papers to be read before the Physical Society, and with a vivid enthusiasm urged dressers and others to undertake some line of inquiry. His splendid optimism was infectious, and his cheery manner and his attentive kindness greatly alleviated the suffering of his patients. His visits to the wards were largely attended, and when he left the particular place he occupied was hard to fill. He was a really great clinical teacher. His lectures in systematic surgery were carefully prepared, and he told me that each year he went over the subject afresh, trying to put the points more clearly than before. For years he gave three lectures a week for three months with scarcely an omission, with no sign of failing energy or loss of interest. His delivery was clear, his material well arranged, and the lectures made attractive by the fact that he was able to draw his illustrations from his own practice. In the clinical lectures he was at his best. The points were clearly set out with keen interest, and the subject enriched by illustration from a wealth of experience.

Each year he gave one lecture at least on his mistakes. For instance, after removing a breast for supposed carcinoma and finding a simple cyst he would, as was his practice, bring the specimen before the students (who in that day filled the operating theatre), show the error, and promise a clinical lecture upon the subject. His summary of the case before an operation was also admirable as a clinical method. The audience knew what he thought, and could see whether he was right or wrong, and Bryant never hesitated to acknowledge the error, and to show, if possible, how such might be avoided.

The many specimens he added to the museum at Guy's Hospital are evidence of the interest he took in the scientific side of his work, and the watercolour drawings made under his directions by Mr. Hirst form probably one of the most valuable collections in London. The museum of the College of Surgeons shared with that of his own hospital in these gifts, many from private sources. His interest in the preservation of specimens was probably derived in the first place from his father, who sent several specimens

to the museum at Guy's Hospital. Not only did he work out the naked-eye appearances; he also had microscopic examinations made, and many reports from the pen of Sir James Goodhart, then pathologist to the College of Surgeons, will be found in his papers in the Guy's Hospital Reports. It is well to mention these points, for many may have looked upon Mr. Bryant as a practical surgeon only, little knowing the trouble he took to investigate the pathology of his cases.

The appearance of his "Practice of Surgery" in 1872—a book long expected—created somewhat of a sensation, partly because of an attack made upon it by a review in one of the journals, but chiefly because such a book was much needed, and the author was well known. At that time Erichsen's two large volumes were beyond the scope of the ordinary student, while the smaller books, such as those of Fairlie Clark and Druitt, were inadequate and too brief to be of real service. It was necessary for the student, therefore, to rely upon the systematic lectures on surgery. Holmes's smaller "Surgery" did not appear till 1875, when it at once became a formidable rival to Bryant's volume. The second edition appeared in 1876 and a third in 1879; these later editions were issued in two volumes. A comparison shows how much care the author had expended on these later editions, and the ready sale was the best proof of the usefulness of the work. It was well received in America, where it was recognised as a sound exposition of British surgery and became a popular text-book. Looking through this book to-day, one cannot but be struck by the large amount of original material it contains, and by the excellence and variety of the illustrations. It was, indeed, largely a record of his own work and practice, amplified by the co-operation of several of his colleagues.

Bryant was a steady contributor to the Guy's Hospital Reports, where will be found many admirable papers on practical subjects, with here and there original observations and methods of treatment. For some years he contributed cases to the hospital column of the *Lancet*. It was his practice to look through the clinical reports each month, taking those he wished to have copied. In this way he had always ready a considerable number of cases from which a selection could be made. Of the many papers he contributed to the societies it would be impossible to speak here.

Reference may be made to that on Stephen Smith's amputation at the knee-joint, read before the Medico-Chirurgical Society, as a good example of his style.

In no account of Mr. Bryant's work, however brief, could his uncompromising opposition to Listerism be omitted. In a man so open to the trial of new methods this refusal to accept and to adopt the antiseptic system was the more remarkable. It is difficult to say why he refused to recognise the value of the method, or why he so openly tried to discredit it, especially when the results obtained by one of his colleagues, the late Sir Henry Howse, could so easily be examined. But Mr. Bryant, while declining to use the carbolic spray, employed a weak solution of iodine and paid increased atention to cleanliness. These added to careful after-treatment, while securing a large measure of success, did not altogether prevent wound infection, which was rapidly disappearing under the use of Lister's methods.

On retiring from Guy's in 1888 at the age of 60, Mr. Bryant was still in his prime. The severance from his old hospital and school, where he had worked so long, was a profound grief to him. He could ill conceal the emotion it evoked. He loved the place and all it meant to him. He would speak with enthusiasm of his own teachers, especially of Aston Key and of Cock, and, whether he succeeded or not, he never failed in his effort to increase and spread the fame of his hospital and school. The punctuality of his attendances was remarkable, and it was a matter of wonder to many of us how he managed his hospital work, his lectures, and, when so required, the college examinations, in addition to a busy private practice, without sign of fatigue. Fortunately he found in the Bolingbroke Hospital an outlet for his energies, and it was there he finished his active public career, having contributed in no small degree to raise the position of that hospital and widen its influence. There he adopted all the newer methods of sterilising dressings and instruments, and, in a sense, he came to his own.

Mr. Bryant's vigour carried him well over 80, and when he had passed this age he still attended an occasional dinner, and conversed with rare interest about things present and past. At 80 he still carried himself well, exhibiting to the last much of his cheerful, optimistic character.

Second-Lieut. G. B. MONK,

Killed in action on December 18th.

Second-Lieut. G. Bertram F. Monk, born September 15th, 1891, in Wiesbaden, Germany, where his father practised as a dentist. At the age of 11 years he was sent to England, and educated at St. George's School, Harpenden, Rev. Cecil Grant, Head Master. At the age of 19 he went to the University of Michigan, U.S.A., and took his degree of D.D.S. Returning to England in the Summer of 1913, he entered Guy's Hospital to study for his Medical and Dental Degrees. He became a member of the Artists' Rifles, and took up his duties with enthusiasm. He left for the Front, in France, with that Regiment, and shortly after arrival with a number of other Artists Rifles was offered and accepted a commission in November last in the 2nd Batt. Royal Warwickshire Regiment.

The Regiment made an attack on the German trenches on the night of December 18th, where he met his death.

The attack received a special commendation from the Corps Commander in a telegram to the Royal Warwickshire Regiment for their determined attempt.

Mr. Charles B. Monk writes: "It is indeed gratifying and comforting to his mother and to me to realize how much he was appreciated at Guy's. His heart was entirely with Guy's. He had made up his mind years ago that he was going to study at Guy's, and that, to anyone who knew him, meant that he *was* going to Guy's, as he was not easily turned from his resolves.

Pray accept our best thanks for your sympathetic letter."

2nd Battalion The Royal Warwickshire Regiment,
7th Division. 4th Corps,
British Expeditionary Force,
December 22nd, 1914.

Dear Sir,—As the Senior Officer left in the Battalion after the action on the 18th instant, may I on behalf of all ranks offer to you our deepest sympathy in the death of your son.

Your son died a very gallant death. He was found together with four other officers and thirty-four men within a few yards of a German machine gun, and it was obvious that he was one of a party that had made an extraordinarily gallant effort to capture the gun and prevent it killing their comrades who were coming up behind.

We buried him next morning on the spot on which he fell.

May I add my own personal sympathy with you in losing a son whose bright personality had endeared him to all ranks, and who gave great promise of becoming a really good officer.

Believe me, yours sincerely,
(Signed) J. H. G. WHITE (Captain).

Artists Rifles,
British Expeditionary Force,
France,
28th December, 1914.

Dear Mrs. Monk,—You will have received the sad news of your son's death before this letter reaches you. He was in my company before he left us to go as an officer to a Regular Regiment, and I am writing to tell you how grieved we all are at the loss of a comrade whose character we knew and admired, but we are proud that he died so splendidly.

He was killed during an attack on the German trenches on the night of the 18/19th December. Of the comrades who went with him from the Artists Rifles—Second Lieutenants Standring and Pearce died of wounds; Second Lieutenant Rought is missing, and Second Lieutenant Pickup wounded—all in the same engagement.

The following is an extract from a letter written by their Divisional General to our Colonel:—

"Second Lieutenant G. B. Monk was killed right on the enemy's wire entanglement, well in front of his battalion and opposite a machine gun position.

"Second Lieutenant Standring was severely wounded, also well up in front, and died next day from his wound.

"The gallant bearing of Second Lieutenant C. G. Rought, who is missing, has already been brought to your notice."

* * * * *

"While deeply deploring the loss of these most promising young officers, it must be a satisfaction for you to know that they gloriously upheld the traditions of your Regiment."

Another officer from the Artists who was present writes in a private letter:—"Monk was found right up on their barbed wire, so we know how he died. They are going to do what they can to get him mentioned in despatches."

Your son's life has not been wasted, he gave it freely, and he knew the risks he was facing.

The Colonel has ordered the General's letter to be read to all the men in the Regiment and we are proud to remember that your son belonged to "C" Company, and to know that he could not have died a finer death.

Will you please accept the sympathy of the officers, non-commissioned officers and men of your son's old Company.

I am,
Yours very truly,
(Signed) ARNOLD E. BORE, Captain,
Artists Rifles.

Lieutenant E. H. Griffin, R.A.M.C.,
2nd Battalion, The "Queens," 7th Division.
December 28th, 1914.

Dear Dr. Monk,—I was present at the battle at which your gallant son lost his life, and I am writing to give you some particulars in hopes that the knowledge that he bore himself so bravely will help you to bear the irreparable loss. I got to know Bertram quite well during the last few weeks, and the fact that we were both Guy's men tended, I think, to help our friendship. At all events we were living on the same country road, which was constantly searched by the enemy's shell fire. He came into my dressing station one day to consult me when a "Jack Johnson" burst about twenty-five yards off. Although I am an old hand at war, I fear I did not take it as coolly as your son. The day before the action he consulted me as to some skin trouble he was suffering from, and I told him I should have to send him to the rear for radical treatment, but he laughed at the idea of leaving his duty for so small a thing.

On the 18th a general attack was ordered on the German position with a view to keeping the attention of the enemy fixed while important operations took place elsewhere. I was on duty in the trenches when the attacking

party went out. Bertram went up the scaling ladder with a smile on his face. The moment the enemy's fire broke out, it was clear that no one could live in the storm. Our men were assailed with a torrent of rifle bullets, machine gun fire and hand grenades. The bravest might have flinched before this awful ordeal. As the fire died down the wounded began to crawl back to our lines, our patrols devotedly helping them in. As the night wore on and I saw nothing of the officers of your son's regiment I began to fear he was amongst the killed, or was lying too badly wounded to come in.

At daybreak the Germans made signs for us to come and pick up our wounded. I went out and after a long search I found your brave son just where I should have expected. He was lying dead within thirty yards of the German trenches, half-way across the wire entanglements, his right hand outstretched as though pointing the way to his men. Death must have come instantaneously to him, for his head was pierced by two bullets from the machine gun. He was buried between the English and German trenches with his comrades. On Christmas day we had another armistice to finish clearing the ground, and a funeral service was held, attended by a large gathering of German and English officers. It was a strange and impressive sight.

Perhaps when—(and if)—I get back to town, you would like me to call and give you some further particulars.

Asking you to accept my deepest sympathy.

Believe me, yours very sincerely,

(Signed) ERNEST H. GRIFFIN.

Papers by Guy's Men.

H. L. Eason, M.D., M.S. Lond.: A case of spontaneous recovery from detachment of the retina.—*Lancet*, January 2nd, 1915.

A. R. F. Evershed, M.R.C.S., L.R.C.P.: Insomnia and suicide.—*Ibid.* December 26th, 1914.

Sir James F. Goodhart, Bart., M.D., F.R.C.P.: Hyaline casts in the urine.—*Lancet*, January 2nd, 1915.

John D. Malcolm, F.R.C.S. Edin.: Pneumoperitoneum of three days duration following resecting of a carcinomatous rectum; evacuation of the gas and of a pelvic abscess; recovery; no recurrence after five years.—*Lancet*, January 9th, 1915.

L. S. Pilbeam: Analgesia.—*British Dental Jovrnal*, January 1st, 1915.

A. W. Sheen, M.S. Lond., F.R.C.S. Eng.: Some experiences of shell wounds in the present war.—*Lancet*, January 2nd, 1915.

E. W. H. Shenton, M.R.C.S., L.R.C.P.: X-rays in war time.—*Ibid*, January 2nd, 1915.

A. H. Tubby, M.S., F.R.C.S.: Nerve concussion due to bullet and shell wounds.—*British Medical Journal*, January 9th, 1915.

Urinary Pigments and Chromogens.

Urobilin and Bile Pigment.—Bile pigment is formed in the liver and excreted in the bile into the intestine where it is reduced by bacterial action to the principal pigment of the fæces, stercobilin, which is identical with urobilin. Both bile pigment and urobilin are to a certain extent absorbed into the portal blood from the intestine and re-excreted by the liver in the bile, so that bile always contains appreciable amounts of urobilin. When the flow of bile is impeded in any way, both these pigments pass into the general blood stream and are excreted by the kidneys. This excretion appears to be more efficient for urobilin than for bile pigment.

Urobilin can be recognised directly in the urine by spectroscopic examination, a broad band being seen between the green and the blue. When this band does not show clearly, the urine is strongly acidified with acetic acid and extracted in a large test tube with about a quarter of its volume of amyl alcohol. The pigment passes to the amyl alcohol, which shows the band and gives a green fluorescence on the addition of saturated alcoholic zinc acetate. Normal urine does not give any of these tests, but on long standing after the addition of acetic acid enough colourless urobilinogen, which is normally present, may be transformed to urobilin for the band to become visible.

Bile pigment may often be recognised by applying Gmelin's nitric acid test directly to the urine, and, as with urobilin, it is extracted by amyl alcohol in the presence of acetic acid, so that Gmelin's play of colours can be obtained by pouring the amyl alcohol extract on to slightly diluted nitric acid. Small amounts of bile pigment are, however, best recognised as follows: About 50 c.c. of urine are rendered alkaline with ammonia and saturated with ammonium chloride. After standing a few minutes the resulting precipitate of ammonium urate is filtered off and nitric acid is poured on to the filter paper whilst it is still wet. The play of colours is seen at the edge of the region of the filter paper, which is acted on by the nitric acid.

Jaundice.—Increasing obstruction to the flow of bile causes first the appearance of urobilin in the urine, then both urobilin and bile pigment, and, finally, when the obstruction is complete, bile pigment only. Similarly, when the obstruction is passing off, the bile pigment diminishes and the urobilin increases till urobilin alone is left, which finally disappears. The urobilinuria of disappearing jaundice is very conspicuous owing to the large amount of bile pigment in process of excretion. It is difficult to recognise small quantities of urobilin in the urine in the presence of much bile pigment, so that noting the colour of the

stools and demonstrating the almost complete absence of urobilin therein is a better way to establish the completeness of the obstruction causing the jaundice than an examination of the urine.

When *right sided cardiac failure* leads to engorgement of the liver, urobilinuria is often conspicuous, but bile pigment is present only in extreme cases.

Cirrhosis of the liver.—In this condition urobilin is present in the urine usually associated with uroerythrin. Bile pigment appears only in extreme cases.

Acholuric jaundice.—As a generalisation the presence or absence of bile pigment in the urine runs closely parallel with the occurrence of jaundice of the sclerotics, but in acholuric jaundice the sclerotics may be jaundiced and bile pigment may be easily detected in the blood serum, while the urine contains urobilin, but no detectable bile pigment. The jaundice is, in these cases, associated with unusual fragility of the red corpuscles, and the bile pigment is supposed to be too intimately associated with the proteins of the serum for it to be excreted by the kidneys. It is, however, by no means unusual in other cases of slight jaundice to find the blood serum definitely jaundiced when the amount of bile pigment in the urine is by no means conspicuous.

Pyrexial conditions.—Urobilin is nearly always recognisable, and is usually associated with uroerythrin. The urobilin is well marked in pneumonia, and is especially marked in the pyrexial attacks of malaria. Here the urobilinuria is to be attributed to rapid destruction of the hæmoglobin, while in pneumonia engorgement of the liver is not infrequent.

In *Pernicious anæmia* and other conditions in which there is excessive destruction of hæmoglobin, urobilin is always detectable in the urine, the amount present varying from but slight excess over the normal trace to quantities which can be easily detected.

Indican, Uroroseinogen, and Phenols.—Indican, or indoxyl sulphuric acid, is tested for as follows: To about 5 c.c. of urine in a test tube are added an equal volume of strong hydrochloric acid and about 2 c.c. of chloroform. Liquor sodæ chlorinatæ diluted with about five times its volume of water is then added drop by drop, the test tube being inverted after each addition of one or two drops until the maximal colour is obtained. The hydrochloric acid liberates indoxyl, which is oxidised to indigo, which is, in its turn, extracted by the chloroform. Excess of the hypochlorite further oxidises the indigo to a colourless substance. Hence it is added with care. To obviate this difficulty ferric chloride has been proposed as the oxidising agent, but it is not efficient.

Uroroseinogen may be converted to urorosein in the previous test, but a better way is, after the addition of an equal volume of hydrochloric acid, to add one or two drops of 0·5 per cent. sodium nitrite. The resultant urorosein has a red colour, and is extractable by amyl alcohol, not by chloroform. The extract shows a broad band in the green near the D line. The substance that gives this test is indol-acetic acid, or a body nearly related to it.

Excess of nitrite in the urine interferes with both the above tests, so that, if the urine is at all decomposed, it should be tested for nitrite by the addition of potassium iodide and dilute sulphuric acid, when, if nitrite is present, iodine is liberated.

Phenols.—The urine is acidified with dilute sulphuric acid and extracted with ether. The ether extract is evaporated, and the residue heated with Millon's reagent, when a red colour shows the presence of phenols.

The above substances are derived from constituent amino acids of protein by the action of bacteria mainly belonging to the coli group. Tryptophane yields indolethylamine, indolacetic acid, skatol, and indol. Indolethylamine is converted to indolacetic acid in the liver. Indol is oxidised to indoxyl and excreted generally as indican. Skatol gives no good tests, and so has been little studied. Tyrosine can yield various phenols of which the commonest apparently is para-hydroxyphenyl acetic acid.

The phenols and indoxyl when in excess may be excreted with glycuronic acid, the urine giving a definite, but slow, reduction of Fehling's solution. They can be recognised in nearly all urines, but the amount is normally small. For the recognition of a pathological excess simple quantitative methods would be very desirable. At present these are not available, but with experience a rough estimate can be obtained of the amount present in relation to the specific gravity of the urine, or better to the nitrogen or urea it contains. Lack of such estimation and the use of unreliable tests have led to considerable confusion on this subject, so that it has often been asserted that the occurrence of indican, etc., is too variable to be of any value. This is certainly not the case, though the factors which cause pathological indicanuria, etc., are undoubtedly complex.

The significance of variation of the relative amounts of the three groups, indican, uroroseinogen, and phenols are unknown. For the present it is best to consider all three together under the term indicanuria.

Indicanuria may result from the presence of putrefactive bacteria in an abscess, but in general they are formed by bacterial decomposition in the intestine, and are an index of such decomposition. Bacterial growth takes place mainly in the large intestine, but in many animals, including man, proteins are mostly absorbed before they reach the large intestine, so that the decisive factor is the control of bacterial growth involving decomposition of proteins in the small intestine. The factors that inhibit such decomposition are: little protein in the food, the antiseptic action of the gastric HCl, rapid digestion and absorption of proteins, and effective movement and emptying of the small intestine. Factors aiding decomposition are a

diet rich in proteins, lack of gastric HCl, ineffective digestion of proteins, and ineffective movement and delay in the small intestine.

Indicanuria is very conspicuous in obstruction affecting the small intestine, provided food be present, but obstruction of the large intestine does not have this effect unless there is also delay in the small intestine. Any cause of impaired movement, such as tuberculous peritonitis or even ascites, may result in indicanuria.

Associated with diminished gastric HCl and diminished gastric digestion, indicanuria is found in pernicious anæmia, gastric carcinoma, etc., and in some cases of gastro-jejunostomy. It does not occur in constipation unless there is also ileal delay or diminished gastric secretion.

The presence of blood in the alimentary canal frequently causes indicanuria, presumably because of the difficulty with which hæmoglobin is digested and absorbed.

A cow's milk diet favours indicanuria for three reasons: gastric secretion is diminished, the diet is rich in protein, and the protein is rich in tryptophane. This effect is well marked in children, so that indican can always be recognised in the urine of children who are fed mainly on cow's milk. The amount, however, is not large, if digestion is proceeding properly. In some cases, where there is presumably excessive putrefaction, indicanuria is very conspicuous.

J. H. RYFFEL.

The Dental Society.

AT a meeting of the above society, held on Tuesday, January 5th, a paper was read by Mr. Thorn on "Dental Electro-Therapeutics."

The president, Mr. F. Bocquet Bull, occupied the chair. In his opening speech he announced that the Dental Council, in view of the present crisis, had decided that the Annual Dinner should not be held this year. Casual communications were called for, and two interesting cases were presented by Messrs. Pearce and Deverall.

Mr. Thorn's paper was extremely interesting and nstructive, but unfortunately the subject was one which did not provoke much discussion. We would urge members, when choosing subjects for their papers to keep this point in view, otherwise much of the value of these meetings is lost.

BOOKS, ETC., RECEIVED.—The Westminster Hospital Gazette, The Prescriber, The New Zealand Medical Journal, The Hospital, The Nursing Times. St. Bartholomew's Hospital Journal, St. George's Hospital Gazette.

National Statues.

LOOKING in the Guy's Museum of Antiquities in search of some appropriate link with the past, we came across the *Saturday Magazine* of August the 2nd, 1834. On the frontispiece is an excellent reproduction of the statue of Thomas Guy, in the Chapel, and inside the following account of a man of great intelligence, industry and piety, and, above all, the greatest philanthropist of his day:—

NATIONAL STATUES.

No. VII. STATUE OF THOMAS GUY, IN THE CHAPEL OF GUY'S HOSPITAL, SOUTHWARK.

Teach me to soothe the helpless orphan's grief,
With timely aid the widow's woes assuage,
To misery's moving cries afford relief,
And be the sure resource of drooping age.

With great pleasure we place on our list of National Statues that of GUY, the amiable friend of the poor and unfortunate, and founder of the noble Hospital which bears his name. The monumental group represented in our engraving, is of white marble, and stands against the wall, facing the visiter as he enters the hospital-chapel. It was executed by the late Mr. Bacon, in 1779, and is said to have cost 1000*l*. Mr. Guy is represented in his livery gown, holding out one hand to raise a poor invalid lying on the earth, and pointing with the other to a distressed object, carried on a litter into one of the wards, the hospital being in the background. On the pedestal is this inscription;

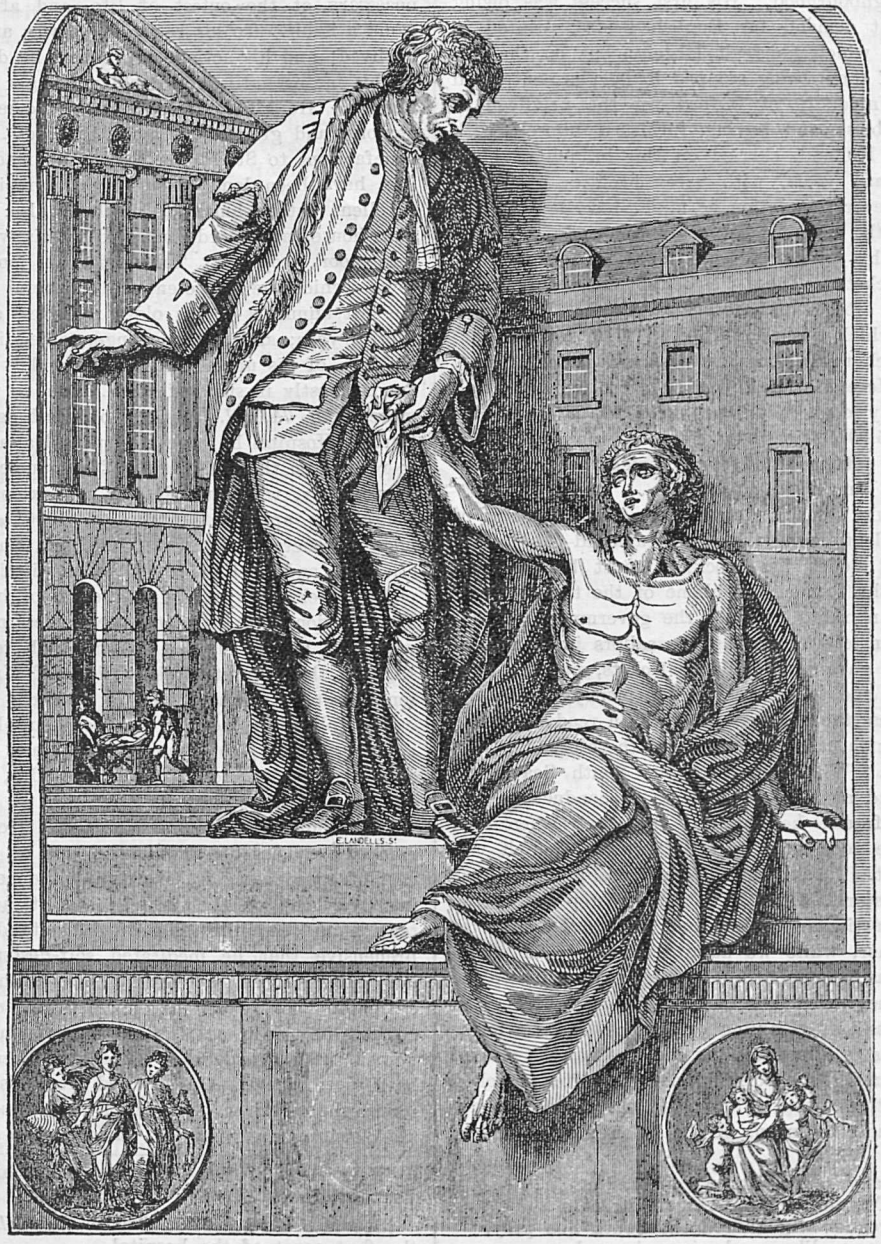
Underneath are deposited the remains of
THOMAS GUY,
Citizen of London, Member of Parliament, and the sole founder of this hospital in his life-time.
It is peculiar to this beneficent man to have persevered, during a long course of prosperity and industry, in pouring forth to the wants of others, all that he had earned by labour, or withheld from self-indulgence.
Warm with philanthropy, and exalted by charity, his mind expanded to those noble affections which grow but too rarely from the most elevated pursuits.
After administering with extensive bounty to the claims of consanguinity, he established this asylum for that stage of languor and disease, to which the charity of others had not reached: he provided a retreat for hopeless insanity, and rivalled the endowments of kings.
He died the 27th of December, 1724, in the 80th year of his age.

THE

Saturday Magazine.

Nº. 134. AUGUST 2ND, 1834. PRICE ONE PENNY.

UNDER THE DIRECTION OF THE COMMITTEE OF GENERAL LITERATURE AND EDUCATION APPOINTED BY THE SOCIETY FOR PROMOTING CHRISTIAN KNOWLEDGE.



THE STATUE OF THOMAS GUY, IN THE CHAPEL OF GUY'S HOSPITAL.

Thomas Guy, the son of a lighterman and coal-dealer, was born in Horsleydown, Southwark, in 1645. He was apprenticed to a bookseller in Cheapside, and having been admitted a freeman of the Stationers' Company in 1668, was received into their livery in 1673. He began business with a stock of about 200*l.*, in the house which, till lately, formed the angle between Cornhill and Lombard Street, but which has been pulled down for the improvements now making in that neighbourhood. His first success was owing to the great demand for English Bibles, printed in Holland, in which he dealt largely: but on the importation of these being stopped by law, he contracted with the University of Oxford for the privilege of printing Bibles; and having furnished himself with types from Holland, carried on this branch of business for many years, with great profit.

But whatever foundation he might have laid for his future wealth, in the usual course of trade, no small portion of his property arose from his purchase of seamen's tickets. These he bought at a large discount, and afterwards subscribed in the South Sea Company, which was established in 1710, for the purpose of discharging those tickets, and giving a large interest. Here Mr. Guy was so extensively, as well as cautiously concerned, that in 1720, he was possessed of 45,500*l.* stock, by disposing of which when it bore an extremely advanced price, he realized a considerable sum.

If it should seem to detract from the character of this benevolent man, that he trafficked in sailors' tickets, and South Sea stock, it must be observed, that as to the former, the blame of the tickets being brought to market, lay with the government of that time, who instead of paying the sailors in money, as they ought, gave them bills or tickets, payable at a future day: and to such as wanted money, these were useless, unless the holders could obtain ready cash for them, in which case, discount, and therefore, loss, was unavoidable. With regard to the South Sea stock, Mr. Guy had no hand in framing or conducting that scandalous fraud; he obtained the stock when low, and had the good sense to sell it at the time it was at its height. Never, indeed, can we approve of that speculative spirit, which leads men to step out of the line of a particular calling, and to "*make haste* to be rich;" nor, while we admire the *mode* in which a fortune has been spent, and contemplate some splendid endowment that has derived its origin from the "bad success" of gambling or avarice, can we be so far misled as to allow that the end justifies the means. Gay, who, under the form of a fable, often couched just and biting satire, alluding to the large fortunes suddenly made, by means of the "South Sea bubble," remarks;

> How many saucy airs we meet,
> From Temple-bar, to Aldgate-street!
> Proud rogues who shared the South Sea prey,
> And sprung, like mushrooms, in a day.

While we are compelled, in this sketch of Mr. Guy's life, to associate his name with one of the most infamous transactions in the commercial history of our country, it is due to his memory, as well as to the cause of Christian charity, to add, that no dishonourable imputation ever attached to him on this score.* Be it remembered, that much of his money was acquired by labour and perseverance, as well as by that practice of self-denial, which probably was necessary at the outset of life, and afterwards became a habit. To his relations he was attentive while he lived; and his actions prove that he did not hoard up his means until they could no longer be of use to himself. He kindly lent money to some of his connexions, and granted annuities to others. His liberal benefactions to St. Thomas's Hospital, made during his life, have been long known and appreciated in that excellent establishment. He had, also, founded an alms-house (afterwards endowed by his will) for fourteen poor people, at Tamworth, his mother's native town, which he represented in several parliaments. He left annuities to his older relatives, amounting to 870*l.* a year; and to the younger, extending to grandchildren of his uncles and aunts, he left stock in the funds, mostly in sums of 1000*l.* each, to the extent of more than 74,000*l.*, besides bequeathing land. To Christ's Hospital he gave a perpetual annuity of 400*l.*, to receive on the nomination of his trustees, four children yearly, who must be his connexions: and there are always applicants. He left 1000*l.* to discharge poor prisoners in London, Middlesex, and Surrey, at 5*l.* each, and another 1000*l.* to be distributed among poor housekeepers at the discretion of his executors. The erection of the hospital, the earliest part of which was built by Mr. Dance, is said to have cost nearly 19,000*l.*, the amount of the residue of Mr. Guy's personal property being stated at upwards of 219,000*l.*

The following anecdote has been supplied to us by a correspondent, to whom, for this and other agreeable contributions to our pages, we offer, once for all, our best acknowledgments.

"The munificent founder of Guy's Hospital was a man of very humble appearance, and of a melancholy cast of countenance.† One day, while pensively leaning over one of the bridges, he attracted the attention and commiseration of a by-stander, who, apprehensive that he meditated self-destruction, could not refrain from addressing him with an earnest entreaty, 'not to let his misfortunes tempt him to commit any rash act;' then, placing in his hand a guinea, with the delicacy of genuine benevolence, he hastily withdrew. Guy, roused from his reverie, followed the stranger, and warmly expressed his gratitude; but assured him he was mistaken in supposing

*Notwithstanding the flippant and unfair remarks of Pennant, in his *History of London.*

†See also his statue in bronze, by *Scheemakers,* in the first court of the hospital.

him to be either in distress of mind or of circumstances, making an earnest request to be favoured with the name of the good man, his intended benefactor. The address was given, and they parted. Some years after, Guy, observing the name of his friend in the bankrupt list, hastened to his house; brought to his recollection their former interview; found, upon investiagtion, that no blame could be attached to him under his misfortunes; intimated his ability, and also his full intention to serve him; entered into immediate arrangements with his creditors, and finally, re-established him in a business, which ever after prospered in his hands, and in the hands of his children's children, for many years, in Newgate Street.

His humane plan of founding an hospital having been matured, Guy, at the age of seventy-six, procured from the Governors of St. Thomas's Hospital, Southwark, the lease of a large piece of ground for a term of 999 years, at a rent of £30 a year. Having cleared the space which was then occupied by a number of poor dwelling-houses, he laid the first stone of his new building in 1722. He lived to see it covered in: but before the excellent machine had begun to work, he was laid in the grave; for the hospital received within its walls the first sixty patients on the 6th of January, 1725. His trustees faithfully effected the completion of his great and good design, and soon procured an Act of Parliament for establishing the foundation, according to the directions of his will. Large and profitable estates were afterwards purchased in Herefordshire and Essex, for the benefit of the institution: the lease of an additional piece of ground was also obtained, for which, with the former, the governors still pay an annual sum to St. Thomas's. On this were erected two handsome wings, connected by an iron railing and Gates: and Guy's Hospital now occupies a site of five acres and a half. Against the stone front of the building, on entering, are two emblematic figures, Æsculapius, the heathen god of medicine, and Hygeia, the goddess of health, daughter of Æsculapius. In the west wing is the chapel; and opposite, in the east wing, which is the older, is the Court-room. Here is a picture of Guy. Also a portrait by Phillips of the present Treasurer, B. Harrison, Esq., who has filled that situation for nearly thirty-five years, and under whose kind and liberal management the hospital continues to prosper, and to fulfil the good its pious founder intended. The wings, likewise, contain the residences of the principal officers.

Passing through the arches in the centre, we come to a long colonnade, on each side of which are two quadrangles, containing the wards for patients, there being altogether five hundred and thirty beds. Some of the wards are for surgical cases, one for accidents; the remainder are filled according to circumstances. The buildings are airy, and well suited to promote recovery: and it is estimated that of about three thousand patients who enter in the course of the year, (the present average of admissions,) nine-tenths go out cured. Besides this, the hospital relieves upwards of fifty thousand out-patients. The means of usefulness, indeed, enjoyed by this admirable establishment, have lately admitted of an abundant increase, by the munificent bequest of 196,000*l*., made a few years since by Mr. Hunt; a hundred inmates more being accommodated in consequence.

Passing directly through the colonnade, we arrive at the portion of the building which is assigned for the charge of twenty-four female lunatics; some of whom, though they entered apparently hopeless cases, (as the epitaph of the founder implies,) have, we are happy to say, quitted their safe and hospitable retreat in a sound state of mind.

Further on, amidst trees which flourish well and give a look of cheerfulness, so delightful to many a languid sufferer when permitted to walk forth into the air, we reach the Museum. This is a neat modern building, comprising a valuable surgical collection, the principal feature of which is a vast variety of wax models, illustrative of the wonders of the human frame, and of remarkable cases of disease, executed with surprising accuracy by Mr. Joseph Towne of Guy's Hospital. M.

Appointments.

Naval.

Surg. Probationer C. T. Helsham to the *Crusader*.

Royal Army Medical Corps.

To be temporary Lieutenants: C. C. Holman, A. L. George, J. A. Delmege, S. J. Ormond, H. E. H. Tracy, G. Matthews, Owen Richards, A. R. Wilson, Harold Wacher, J. W. Grice, Evan Evans.

2nd London General Hospital.—A. W. Ormond, F.R.C.S., to be Captain.

2nd North Midland Field Ambulance.—Lieut. C. M. Cowper to be Captain (temporary) (T).

2nd Home Counties Field Ambulance.—Capt. G. T. Willan to be Major (temporary).

3rd Home Counties Field Ambulance.—To be Lieutenant: M. C. Hayward.

To be Lieutenants on probation: W. M. Lansdale, H. P. Whitworth.

Attached to other than medical units.

C. F. Searle (from 1st East Anglian Field Ambulance) to be Lieutenant.

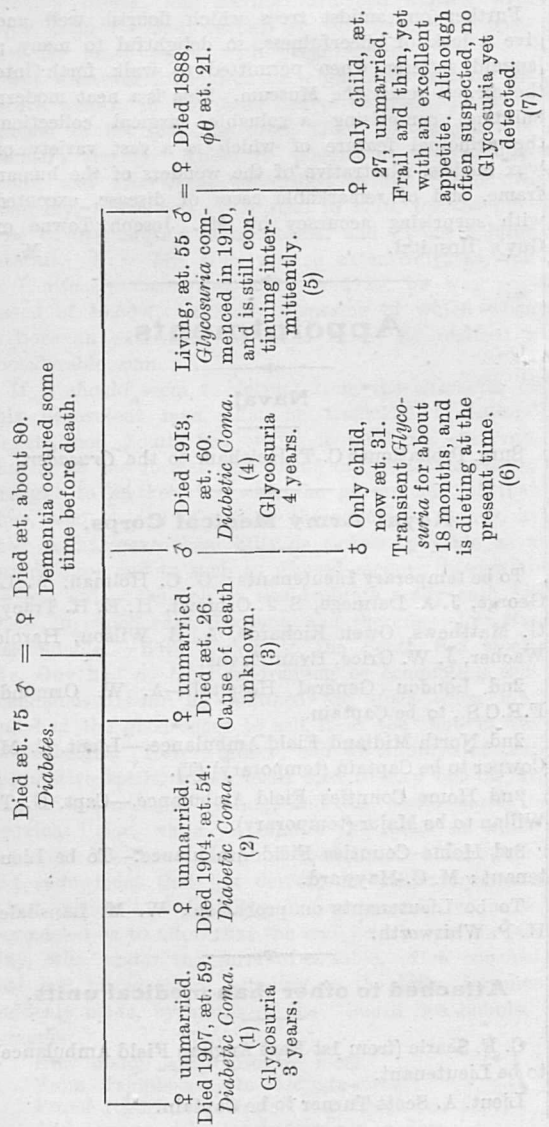
Lieut. A. Scott Turner to be Captain.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

DEAR SIR,—On reading Dr. Hammond's letter mentioning certain members of the same family afflicted with diabetes, published in your issue of December 19th, 1914, I was reminded of quite a noteworthy example occurring in a family well known to me. I venture to append a medical history arranged in tabular form:—



It will be seen that the disease tends to appear earlier with successive generations. The father lived until he had reached old age; in the case of the sons and daughters, diabetes did not appear until after the mid-point of average human life; with the grandson its onset is comparatively early. One curious feature is that (1), (2), and (4) were each out and about only the day before they died. It is an interesting speculation to consider how far the inherent tendency to diabetes in the one, and to cerebral weakness in the other, of the original parents, combined to predispose to diabetic coma in the children. In view, also, of the alleged frequent association of diabetes and tuberculosis, the subsequent history of (7) should be very instructive.—Yours, &c.,

Hereford, CECIL WORSTER-DROUGHT.
January 4th, 1915.

DEAR SIR,—In reply to Dr. T. B. Judge Baldwin's interesting letter on the case of acute yellow atrophy reported by me a month ago, the thyroid gland, like all other viscera not mentioned in the P.M. report, was found to be quite normal on naked-eye examination, but no microscopical examination was made and there were no signs of any exophthalmos during the course of the disease.

The case mentioned by Dr. Judge Baldwin is evidently very rare, and I cannot find a similar case reported. In referring to "Pathological Changes of the Thyroid in Diseases," by Rupert Farrant (Royal Soc. Med., 1914, vol. vi., Path. Sect., p. 21), acute yellow atrophy is not mentioned, but it is there stated—that jaundice produces no change in the thyroid gland.—Yours,

Guy's Hospital, R. CURLE.
London, S.E.,
January 12th, 1915.

Change of Address.

Capt. A. S. Liebson, M.O., Rand Light Infantry, Army Post Office, Cape Town, South Africa.

Dr. W. J. Henson, from Elmsett Hall, Wedmore, Somerset, to 2, Derby Street, Mayfair, W.

W. E. Wallis, B.A., M.B., B.C., from Sandon, Bexhill-on-Sea, to The Gables, Groombridge, Sussex.

Lieut. A. N. Leeming, R.A.M.C., No. 10 Casualty Clearing Station, British Expeditionary Force, France.

(*The Editor will be very glad to receive a post card with notes of any change of address.*)

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Guy's Hospital.

IN accordance with annual custom the House Committee publishes for the information of the Medical, Surgical, and Nursing Staff, the following Tables showing the total number of Patients sent during the past year to the various Convalescent Homes connected with the Hospital.

WARDS.	NUMBER OF PATIENTS. 1913	1914
Astley Cooper	46	65
Bright	—	1
CORNELIUS	55	38
Lazarus	42	41
Job	48	59
Naaman	49	59
Luke	69	57
Patience and Samaritan	25	33
Charity	59	29
Dorcas	61	46
Lydia	84	52
Martha	47	66
Eye Wards	20	13
Addison	63	61
Mary	43	51
Stephen	70	40
Esther	48	56
Queen Victoria	32	51
Clinical	80	70
Isolation	—	—
Surgery	1	1
Out-Patients	55	37
Light Department	—	2
	997	928

January 1st, 1915.

The subjoined list gives the distribution of the Patients amongst the various Homes:—

Ascot Priory	166
Bexhill (M.C.I.)	37
" (Little Common, M.C.I.)	37
Bognor (Merchant Taylors' Home)	20
Broadstairs (M.C.I.)	89
Bromley (Brackenhill)	5
Cobham (Schiff Home of Recovery)	75
Croydon (Wallacefield—for Wounded Soldiers)	6
Hadley, Barnet (Children's Home Hospital)	3
Highcliffe-on-Sea (The Burns Home)	77
Rustington Convalescent Home	15
Shooter's Hill (Baroness d'Erlanger's Home)	9
Swanley (Parkwood)	282
Walton-on-Thames (M.C.I.)	52
Weybridge (Mrs. Vernon Carter)	4
" (Mrs. Heald)	3
	880

SANATORIA.

(Beds allocated free of charge to the Hospital by the King's Fund; travelling and incidental expenses, only, paid by the Samaritan Fund.)

Didworthy (Devon and Cornwall Sanatorium	7
Holt, Norfolk (Kelling Sanatorium)	16
	903

HOMES FOR THE DYING.

Friedenheim Hospital	
	904

In addition to the above, 24 patients have been sent to various places for convalescent treatment, principally in co-operation with the Charity Organization Society, and the Invalid Children's Aid Association | 24
928

List of amounts received from Patients in the various Wards, and sums found in Ward Collecting Boxes, etc., for the year ending December 31st, 1914. The amounts received in the previous year are inserted for the purpose of comparison.

	Box Collections. 1914. £ s. d.	Special Donations. 1914. £ s. d.	Totals for 1913. £ s. d.
Front Gate Box	4 16 0	—	4 7 8
Porter's Lodge	2 16 0	—	6 14 10
Out-Patient Depart.	4 11 8	2 1 6	4 6 8
Surgery	13 18 5	1 1 0	12 16 2
Conservation Room	5 18 9	—	7 15 3
Actinotherapeutic Department	—	17 16 0	15 0 6
Massage Department	16 4	—	—
WARDS.			
Addison	1 16 0	24 19 0	5 6 8
Astley Cooper	1 1 5	9 3 6	10 3 10
Bright	2 8 0	26 1 0	5 8 9
Charity	3 10 1	31 6 6	24 11 10
Clinical	2 4 8	11 6 6	31 8 3
Cornelius	4 6	25 13 0	19 0 0
Dorcas	3 19 9	31 2 0	37 1 1
Esther	1 6 11	10 10 0	11 5 11
Evelyn	9 8	5 5 0	—
Eye	2 5 8	10 10 0	5 17 11
Job	6 12 6	27 10 0	32 14 0
Lazarus	3 2 8	28 18 0	13 4 0
Luke	8 15 7	39 7 0	45 19 0
Lydia	2 9 1	17 5 0	20 3 2
Martha	3 5 5	43 12 0	64 10 3
Mary	3 2 4	10 0 0	12 15 10
Naaman	2 12 0	46 6 0	32 15 10
Patience	13 3	15 5 0	10 18 3
Queen	6 6 0	25 12 6	68 9 10
Stephen	1 18 6	66 15 0	4 17 3
	£91 1 2	£527 5 6	£507 12 9
Total for 1914	£618 6 8		

Consulting Engineer's Report for the Year 1914.

The Treasurer,

Guy's Hospital, London, S.E.

MY LORD,—I enclose the Statement of Accounts for the Central Station for the year ending November 30th, 1914.

During the year Tabard House has been completed and the Ward Maids are now using this Hostel. The Orthopædic Workshops have been nearly completed and the Bakery has been remodelled. Work has also been carried on in connection with the new Bacteriological Department, and with the Clinical Laboratories, and the new Out-Patients' Tuberculosis and Orthopædic Departments, which work is not yet completed.

These additions have made a further demand on the Central Station for steam and electric energy.

Engine House Plant.

This plant, consisting of engines, switchboard, pumps, etc., has all been kept in good order, and the 30 k.w. set, which was taken out a few years ago to make room for the 120 k.w. set, has been re-erected in the extension to the Engine Room under Tabard House, and will very shortly be working.

Boiler House Plant.

The boilers and economisers have been kept in good condition, and have been regularly tested and passed as satisfactory by the Vulcan Boiler Insurance Company.

The amount and cost of coal used in the Central Station in each year since 1904 are shown by the following statement:—

Summary of Coal used and Cost per Annum since 1904.

Year.	Amount in Tons	Cost. £ s. d.
1904	4,887	3,867 8 0
1905	5,192	3,867 2 1
1906	4,784	3,576 3 11
1907	4,774	3,998 2 5
1908	5,132	4,668 10 0
1909	4,824	4,073 19 6
1910	4,437	3,665 7 10
1911	4,456	3,694 4 2
1912	4,641	4,217 2 9
1913	4,984	4,933 14 3
1914	5,114	5,206 8 5

It will be seen that 130 tons more coal have been used during the year, and that there is an increase in the cost of the coal of £272 14s. 2d.

Electric Light and Power.

Summary of Electricity used and Cost per Annum.

Year.	Units of Electricity used in the Hospital,	Cost per Unit (exclusive of Interest and Depreciation).
1905	237,303	1·458d.
1906	246,504	1·3528d.
1907	296,320	1·16562d.
1908	317,611	1·1093d.
1909	315,671	1·03481d.
1910	300,660	0·97883d.
1911	302,450	0·98484d.
1912	313,710	1·01507d.
1913	327,030	1·00526d.
1914	336,889	1·07682d.

The extra amount of current used during the year in the Hospital was 9,859 Board of Trade units.

The cost per unit has been slightly increased from 1·00526d. to 1·07682d. The enhanced cost is largely due to the extra cost of coal, and to the charges under Maintenance being somewhat higher than they were last year. Of necessity these charges must vary from year to year, the charge under Maintenance depending on the amount of stores it is found desirable to purchase.

Additional lights to the number of 257 were connected during the year, bringing the total up to about 5,080 lights in use in the Hospital, and 41 additional plugs were connected, making a total of about 1,240 plugs.

One additional electric lift has been installed in Tabard House, and new motors have been fitted for driving machinery in the Bakery, the Electric Plating Department, the Orthopædic Workshop, and in the Coppersmith's Shop.

Nearly four miles of wiring have been used in connection with these extensions.

In addition to the coal the principal items which have caused an excess this year have been in connection with the replacing of various parts of the automatic stokers for the boilers, and in connection with new parts for keeping the engines and accumulators in repair.

Electric Lamps issued from Stock during the Years 1913 and 1914.

Lamps.	1913. Number.	1913. Cost. £ s. d.	1914. Number.	1914. Cost. £ s. d.
Metallic Filament ...	1980	181 10 0	1792	155 13 8
Carbon Lamps	1850	46 5 0	1761	44 0 6
	3830	227 15 0	3553	199 14 2

It will be noticed that the expense for lamps has been reduced during the year, which is satisfactory as it shows that the systematic method of dealing with these stores is still proving successful.

Heating and Hot Water Supplies.

The heating and hot water supplies generally have proved satisfactory.

The additions made during the year have involved the use of about two miles of new piping.

Bakery.

The bakery has during the year been remodelled on the most modern lines as regards sanitation and the manufacture of satisfactory bread. The importance of the Department to the Hospital is evident when it is realized that during the previous year (namely, 1913) 54,750 quartern loaves of bread were made and baked, in addition to 8,700 buns.

The arrangement as now installed consists of a room having tiled floor and walls, and mechanical apparatus for sifting and mixing the flour and mixing the dough, all driven electrically, together with a new oven capable of regulation.

The alterations have proved satisfactory both from the points of view of efficiency and cleanliness.

Surgical Cutler's Shop.

This has proved useful to the Hospital, and it may be of interest if I give the particulars of the work done in this shop during the last year:—

Surgical Instruments for 12 months.

5,025 scalpels.	73 amputation knives.
1,192 scissors.	421 drills.
748 knives.	11 guillotines.
45 saws.	151 needles.
7 choppers.	56 chisels.
316 razors.	71 screw drivers.
144 gouges.	39 forceps.

or a total of nearly 8,300 instruments dealt with.

Electro-Plating Shops.

These have been provided during the year, and will, I think, prove very useful both in connection with surgeon's instruments and other work which requires plating. The arrangement at present installed enables nickel or copperplating to be done as required.

Orthopœdic Workshop.

A screw cutting lathe, burnishing lathe and drilling machine have been installed, all driven by motor.

Coppersmith's Shop.

A drilling machine and burnishing lathe have been installed, driven by motor.

Laundry.

The machinery in the Laundry has been kept in good repair.

I remain, my Lord,
Yours faithfully,
(Signed) THOS. KIRKLAND.

Books recently added to the Wills Library.

BY PURCHASE.

Bigg's Diseases of Nose, Throat, and Ear.
Buxton's Anæsthetics, 1914.
Gould, Elements of Surgical Diagnosis, 1914.
Hutchison and Collier, Index of Treatment, 1913.
Lewer's Diseases of Women, 1912.
Lewis, Clinical Electrocardiography, 1913.
Mills and Humphris, Surgery for Dental Students.
Muir and Ritchie's Bacteriology, 1913.
Mann and Brend's Forensic Medicine, 1914.
Pollard's Minor Surgery and Bandaging, 1914.
Rose and Carless, Manual of Surgery, 1914.
Short, The Newer Physiology, 1914.
Secret Remedies, 1912.
More Secret Remedies, 1913.
Tome's Manual of Dental Anatomy, 1914.
Whittaker's Surgical Anatomy, 1914.

PRESENTED.

Collected Papers, Department of Pathology, University of Oxford, vol. 2, 1911—13. By Prof. Dreyer.
Taylor's Practice of Medicine. By Dr. Frederick Taylor.
Report of the Brompton Hospital Sanatorium, Frimley, Surrey. By Brompton Hospital.
Lane's Operative Treatment of Fractures, 2nd edit., 1914. By Sir W. Arbuthnot Lane, Bart., M.S.
Sir Astley Cooper's Principles and Practice of Surgery, 6th edit., 1839. By Mr. A. H. Todd, M.S.
Tome's A Manual of Dental Anatomy, 7th edit., 1914. By Mr. M. F. Hopson, L.D.S.
Guy's Hospital Reports, xiii., 1867; xvii., 1872; and xix., 1874. By Mr. C. H. Fagge, M.S.
Journal of Physiology (as published). By Dr. A. F. Hertz.
Archives of the Rontgen Ray (as published). By Dr. A. F. Hertz.
Practitioner (as published). By Dr. A. F. Hertz.

For list of books presented to the Library by the late Dr. P. H. Pye-Smith, see GUY'S HOSPITAL GAZETTE for November 7th, 1914, page 426.

Pass List.

University of London.

FIRST EXAMINATION FOR MEDICAL DEGREES.

Inorganic Chemistry, Physics, Biology.

Bonar, T. G. D. | Joseph, D. L. G.
Bouic, J. A. A. | Kerby, E. F.
Mackenzie, Murdo.

University of Cambridge.

At the Examinations for Medical and Surgical Degrees, Michaelmas Term, 1914, the following Candidates were successful:—

SECOND EXAMINATION, OCTOBER, 1914.

Part II. Pharmacology and General Pathology.
J. Stanley Ellis, B.A.

SECOND EXAMINATION, DECEMBER, 1914.

Part I.
W. J. Walters, B.A.

THIRD EXAMINATION.

Part I. Surgery and Midwifery.
P. R. Boswell, B.A.

Society of Apothecaries.

At Examinations held recently the following Candidates were successful:—

Forensic Medicine.

R. Curle. | R. A. Holmes.

Midwifery.

R. A. Holmes.

Nursing News from Letters received at the Hospital or the Institution.

MATRON'S OFFICE,
January 12th, 1915.

SINCE the last issue of the GAZETTE many more letters have been received from our large Guy's contingent abroad, full of appreciation of all remembrance at Christmas time. The efficiency of the postal service is shown by the fact that only two of the packets seem to have failed to reach their rightful owners.

Miss Jolley, Matron of the Royal Southern Hospital, Liverpool, in the Q.A.I.M.N.S. Reserve, who was called up at the beginning of the war, writes from an Ambulance Train, British Expeditionary Force:—

"We hear of changes at the New Year, and I shall be sorry if I have to leave this extremely interesting post. It has given me such an insight into all sides of the war and helps one to fully realise what the cost must be and all the wonderful organisation required. Having worked previously at a Clearing Hospital on a station, it has been interesting to watch the development of the train work, and the great improvements that have taken place for the comfort and treatment of the wounded.

"We have several Indian orderlies on this train. They are most careful and obedient, and make most excellent stretcher bearers.

"It is so strange, passing through peaceful country with the cattle quietly grazing, and then to be within the sound of the guns. Several times we have had a Taube flying over the train and dropping bombs not many yards away. The animals interest me, as usual. In sidings I have come across herds of curious goats and sheep, no doubt part of the Indian troops' camps. How the horses delight in the lumps of English sugar my sister sends me out. I am glad to say the Tommies are very good to them.

"It is inspiring to meet so constantly Guy's people all trying to do their little bit in this tragic expedition. Also, among the patients one finds so many points of interest in people or in places mutually known. The men seem so pleased to hear a woman talking English again. I must not add more now as we are nearing the station where we are to take on the wounded."

Miss Mackenzie Lawson, now back at Boulogne after spending some time at the Duchess of Westminster's Hospital, mentions her first experience of assisting to organise a stationary hospital at Boulogne before her visit to Touquet:—

"When we went to it, it was nothing but a lot of sheds. I was in charge of one shed, and turning it into a ward of 50 beds was a wonderful time, making something out of nothing. It taxed all our ingenuity, the wounded pouring in all the time. We had the honour to receive Lord Roberts' congratulations on our work. I was presented to him just two days before his death.

"The Tommies are simply splendid, so brave and patient and so grateful; every man so ready to give up any little comfort or luxury for a pal who is more badly wounded than himself."

Miss Vine and her sister write, as before, from the hospital ship *Asturias*, January 6th, 1915:—

"Once again we are in Southampton with another large load of patients. These we are now bringing back are not so badly wounded as those in the earlier part of the war.

"It is a short journey we make now (about five return journeys in the fourteen days), but, on the other side we wait a day or so, and therefore have some of the patients two or three days. In these we see a great improvement.

"Some require operation. The other day we had a strangulated hernia. One poor lad of 20 had been lying in a barn for five days, shot in the leg. It was pathetic to see him trying to make us believe it was better than it had been during the five days when he was told it must come off. It was gangrenous, and had to be amputated above the knee. However, on hearing that he would have an anæsthetic and not feel the operation, he became quite cheerful.

"Another patient was a schoolboy of 17. He joined a Territorial Regiment and went out four months ago. Although he had lost a finger on his right hand and had a gunshot wound in the right thigh, he wants to go out again. When the war is over he is going back to school! In the ward where I am working we are 3 sisters and 4 orderlies with 53 patients, so there is always enough to do.

"On Christmas morning a train load of patients came in from the trenches. Of course, they were 'caked' with mud, but after a sleep and a wash they cheered up, and quite enjoyed the remainder of the day. In the morning carols were sung in every ward by the 'choir,' and there were two concerts in the evening.

"At 6 a.m. Boxing Day we sailed for England. One evening we had a Guy's tea party in our cabin. The decorations were reminiscent of Christmas in the hospital, including a 'Charity' horse-shoe and a white satin bow with the Guy's crest and motto, which came from the Sister's Christmas dinner table, 1913.

"The weather during the last six weeks has been trying to most of us, though we consider ourselves hardened sailors. On really rough days 'doing dressings' is somewhat strenuous work, for bowls of swabs

and gauze have a knack of careering down the ward at a critical moment. We are all in turn having 96 hours' leave, so we hope to visit Guy's soon."

Miss Densham (Sister Evelyn) at the Duchess of Westminster's Hospital, says:—

"We have just said good-bye to the sisters and men who came here for three months, Sister Ina (Mrs. Hill) among them. I shall miss her very much. Our first month we were very busy; our beds were filled almost the day they were empty.

"My first 'take-in' I was on night duty in the ward; Sister Ina had charge of on day. There were 116 beds, every one filled during the night. Oh, the wounds, they were a revelation to me, every one of them pouring with pus, not a clean wound among them. The first week was really terrible, nothing could be properly finished; it made one miserable. Gradually things settled down, and now everyone says that we have the best equipped hospital in France. The last month has been quiet, there seems to have been little fighting. Our patients have been medical, rheumatism, and nervous debility, and frost bite. At La Touquet the air is wonderful, so the men's general health improves quickly and their wounds heal. We keep so fit, also."

Miss Constance Strange, from No. 1 General Hospital, sends her remembrances to all friends at Guy's. Just before Christmas she was at No. 12 Hospital:—

"At No. 12 I had a very nice post—night nurse in the enteric camp. There were two of us for four tents, and there were some desperately bad cases. Before that I was on the medical division, where we only had one nurse for 12 tents, 156 patients each! It was impossible to do much for any of them; one spent the night groping from tent to tent in pouring rain. It rains every day in France.

"In spite of the weather I like camp life, and never felt so well in my life. I have had one or two patient's who lived in the Borough and had been either in or out-patients at Guy's. The other day I met a 'bus driver whose route was over London Bridge, and he recognised me as having been very often on his 'bus. With me here, No. 1, there are Sisters Finnis, Prince, Waters, and Sharwood. At No. 12 I often saw Sister Ruth; she was in camp in the next field to our hospital."

Miss Henrietta Denney writes from a Hôpital Complimentaire, No. —, Tréguier, France:—

"We are quite well installed now and getting to understand and like our patients and finding much in them that appeals to our sympathies. The Frenchman ill is much more of a child than an Englishman.

"Our hospital is a convent with 250 beds and room for more. I am in charge of a medical ward of 50 beds with another sister, and as 'pro.' we have a very nice Scotch lady who is visiting Tréguier. She is extremely kind and capable and spares herself no trouble.

"We cannot boast of many comforts, but we may congratulate ourselves that our patients have chaff mattresses and pillows when one hears of the lack of such things elsewhere. We have no pillow cases, and only the coarsest of sheets, and we cannot get a change for love or money. The present sheets have been on the beds for over a month, and as the blankets are green, the dye of which comes off, it is difficult to distinguish by now sheet from blanket.

"My ward is up three long flights of stairs, and the only hot water available is from a tiny boiler at the side of the kitchen stove, quite a long way off across a court yard. Hot water can, therefore, only be used for the very worst cases. The others dabble hands and faces in cold water. Soap is not considered necessary by the authorities, and the towels are the size and thickness of a pocket handkerchief.

"The French soldier cannot, therefore, be blamed if he is dirty. They are untidy, also, but as their clothes never fit they lack encouragement to attain the smartness we associate with our own men. With so few conveniences it is difficult to do as much for them as we should like, but they are very full of appreciation and gratitude.

"I have never spent a happier Christmas, not even at dear old Guy's. Our small efforts to entertain our men met with the greatest satisfaction. We provided cakes, chocolates, oranges, and cigarettes. A lady arranged a lottery for them, and for all who could get up there was a 'pond' in which they fished for penny prizes. There was tremendous excitement over that, and they fished with all the fervour of professional anglers until the pond was empty. With the National Anthems sung at the tops of our voices the day came to a close.

"A few days after about 20 were able to return to the front to be wounded again or perhaps killed. It made us sad to think of. The French doctors are extremely kind, and help us in every way. Of course, their methods are quite different from those we are accustomed to, but they are beginning to find out that we are to be trusted and that our training enables us to do many things they evidently did not think possible at first. The diagnoses and prognoses of the case is freely discussed over the patient, and he is told exactly what drugs he is taking.

"Screens are quite unknown in a French hospital, and it caused much amusement when we introduced one. It is, unfortunately, frightfully heavy and not at all easy to move."

Miss H. Banbury (Guy's, 1909) who has held various sisters' posts since her training, has gone abroad under the auspices of the War Office C.H.R.

On New Year's Day Miss Bromley-Martin's and Miss Kemp's unit, under the auspices of the St. John Ambulance Association, left Victoria for Arc-en-Barois, Chaumont, Haute Marne, France. The unit includes two surgeons, and an anæsthetist, matron, and eleven fully-trained nurses. Of the nurses Guy's supplies four—A. F. Boys, M. J. Eagle, C. May, and S. J. Gibson.

Nurse Gibson is remembered by many with affectionate interest as District Midwifery Coach, Guy's Institution, 1909 to 1911. A letter from Nurse Gibson, dated January 5th, 1915, tells of the safe arrival of the party after a very rough crossing and lengthy train and cart journies.

"The castle is beautiful, with a lovely park; not ready yet, but supplies are on the way. We shall have 250 beds. On Sunday we went to the Intercession Service in the Roman Catholic Church; they had reserved seats for us. I am afraid that for once the people were more interested in us than in their devotions. The country round is very pretty. We can hear the sound of the cannon in the distance, 70 miles away."

Extracts from a letter from Sister Kiddle:—

Clearing Hospital,
Exp. Force.

"We have quite settled down to our new work, and like it immensely, though, of course, we have a great many more difficulties to contend with than at our Versailles Palace. This place was once a boys' day school, and before we came had been used for billetting troops, and consequently was very dirty. In fact the mud had to be scraped from the floors with spades, and after several scrubbings they are beginning to look a little more respectable. We can take in over 400, but as we only keep our patients about twelve hours unless they are too bad to go on, we are not always full up.

"This place is well arranged and works excellently. Our greatest difficulty is the water; every drop has to fetched from the town. We have to wash one patient after another in the same water until it makes one feel quite ill. The drainage is, of course, hopeless; everything has to be carried quite a distance, so the poor orderlies have a great deal to do. The heating is very primitive, in fact, a more feeble invention I never saw. We are all longing to enjoy a real good English fire like the one in the Clinicals' Room. The lighting might be worse, although it is pretty bad—oil lamps; which love to remind you of their existence by pouring forth a volume of smoke. There is quite a good theatre, not often empty.

"The three floors of the building are arranged for acute or minor cases, receiving rooms, etc. The wards for minor cases have only stretchers, and resemble huge rag shops when the patients are tucked away. The acute wards are honoured with beds, most of which, with the bedding, were presented by the Red Cross Society. We are thankful for them in spite of the varied appearance they present: red blankets or brown instead of counterpanes, some beds with top sheets, others with none. The windows are dirty, floors dirty, and an endless amount of dirt seems to honour us, but we are too busy to trouble with such details.

"The approach to our hospital is beyond description—mud ! ! They have tried to improve it, but the soil is too soft and the ambulance waggons so heavy.

"I cannot tell you about the patients: they are just too pathetic for words, and as we have only those who are too bad to be sent further, it would be difficult to find anything cheerful to tell, except they are just splendid bricks !

"The town is very quaint, with houses that remind one of nursery days built of red brick with little green windows. They are beautifully clean outside, but, as Tommies are billetted in them everywhere, the insides cannot be as spotless as before. The roads and pavements are all cobbles, not at all comfy to walk on, and the men must find them awful for marching. Most of the inhabitants have gone, and the whole place is given over to troops, the roads lined with motor wagons of all kinds ready to be off at a moment's notice. The Tommies sit on the road-side cooking their meals, which really look appetising, and stand in the road washing in buckets or old petrol tins.

"I told you of the old ladies who looked after our billet; well, they have gone to Paris, as they were able to get work there. Now some refugee nuns from Yprès are looking after us. It is a most quaint arrangement. They are allowed food and a home in return for their services. One morning at 6 a.m. eight little black-robed figures arrived. We thought that we should shock them dreadfully and that they would be very prim and proper, but they are perfectly sweet. They came from a very beautiful convent which was shelled by the Germans and find the life very different here, cleaning and cooking. In the convent they used to teach little children."

The Good and Evil of War.

A Woman's Thoughts.

"EVIL is but the exaggeration of Good." So spoke a philosopher. Is it possible that such is the case? Are not these two direct antitheses? Can it be that good contains evil within itself? Yes, even so; for the shadow is only possible where there is light. Thus, for example, avarice is the shadow of thrift; selfishness is the dark side of the right instinct of self-

preservation; and truth contains within itself all error. Even war itself is as a coin with obverse and reverse sides of good and evil.

Looking at the subject superficially, we know within ourselves the truth of this in regard to present happenings. Here we are in the midst of a great war, and we vacillate between two views of it. One moment we think thus: what a magnificent opportunity for the display of patriotism, of self-sacrificing devotion; what chances for the development of all the qualities of endurance, patience, and resistance, which ordinarily are exercised mainly for the small unit of self or family, but now can be gloriously enhanced for the good of country; how fine a thing to see the troops go marching by with all the trappings and ornaments of martial uniform, the music, and the flag.

Then our thoughts turn to the other aspect; the ambitions, greed, and hatreds lying behind all the glory; the cruelty, lust, and savagery brought into prominence; the hideous sacrifice of men's bodies wrought with such infinite skill and nourished through the long years by the loving care of the women of their nation; and the still more lamentable loss of those minds of men in which lay the potentialities of all the greatest things. We thought war could bring forth some of the grander, more heroic virtues; but to some that opportunity for development has passed, the noise of battle is over for them and they know only the peace of the Beyond.

And from day to day we have to balance these opposites: the magnificence, the glorious opportunity, and the insane folly that it should be deemed possible by reasoning man that the gaps in the human relationships between nations should have to be filled with the bodies of men.

Recently our books, our papers, and our conversations have been overflowing with talk about civilisation, relapse into barbarism and such like. Some of us have felt self-righteously that *our* culture is the true culture and that the German "Kultur" is evil, poisonous, and a menace to western civilisation. But think for a moment! The basis of present-day German philosophy is an unmitigated Materialism, and is there anyone who can say that in practice the philosophy of the whole of western Europe is not materialistic to a degree. Happy for Britain that its geo-political position makes for an extremely individualistic people and government, and so has saved its materialism from becoming an organised affair of the state, as in Germany. As a lecturer said recently in speaking of the influence of German philosophers on the mass of the people, "We may be thankful that the English people are possessed of a healthy ignorance," and so the preachings of the "Will to Power" philosophy have taken no hold on the English people, and, in fact, book philosophy in this country remains academic. But, nevertheless, the "time spirit" is materialistic.

Can it not be that the great evils of war, the ruin, the devastation, the pain, and the death are but the shadow of war as a great good, a purifier of man's ideas, a destroyer of his false values and an inspiration to a new spirit and a new life. What we need is a "Re-valuation of values," and it may be that here is the agent which will bring our minds to look on life and its meaning afresh and to reconstruct an ideal worthy of a true civilisation. Every great social upheaval brings its spiritual results. As Emerson says, "The triumphs of peace have been in some proximity to war." And our descendants will look back on these days and see therein the causes of a new literature, a new art, a new philosophy, and a new social order.

Again, war is the shadow of the right and noble instincts of self-preservation and race-preservation. Only the individual who struggles is worth anything. Nature preserves the fittest, and rightly so; but we look at this in more than a material sense; we shall not echo with Nietzsche, "the weak must go to the wall." But he who developes in himself all those qualities which most take up all the forces of personality, he who uses the vigour and strength produced in him by conquest of himself and his environment to make an Art of Life,—that man justly dominates and becomes the master of his fellows; and so with nations as with men.

We read history and we see that eternal vigilance is the price of character. It is the small border states, the countries that have had to wage war with nature to win her wealth, the nations that have taken much welding together, that have proved themselves of greatest worth. Bismarck had not read history in vain when he said that a nation must be made by blood and iron; his fault lies in having brought about union in his own country artificially, in having expected to make an empire in a score of years, whereas it takes centuries to make a real unity of a nation. No country, for instance, has greater homogeneity today than France, but this did not come about within a short period, and came only after the shedding of streams of blood, much of it in civil warfare.

And one feels that if Germany, having made her territorial empire between 1850 and 1871, had been content then to let her people grow together, instead of imposing upon them from above a policy, an education, and a "kultur," she might have turned her undoubted genius to a better end than this present war. A new war was not necessary to her growth as an entity; she had not given time for the good of her last campaigns to work in her people. If she had not schemed for a European war, possibly civil strife would have come about, and so much the better for her, for that would have brought a real homogeneity into German nationality. But even as things are, the great exaggeration will pass, and we shall get to the heart of things and find good there.

Materialism, with its accompanying immoralities of militarism, of the power of the few and the impotence of the many, will go; and when the evils of destruction, brutality, and pain have passed, the ensuing period of peace will give men time to revalue their ideas, and, purified by fire, will give birth to a fine spirituality arising out of the ashes of a dead materialism.

Woman, the guardian of the race, is very near to these things in these days; she has for some years past been revaluing herself and her mate. She is too near life ever to be content to throw it away for mere ambitions or schemes of national aggrandisement; but —*she believes in war*, not wherein man takes man's life, but wherein man conquers himself, vanquishes the forces of evil, balances the exaggerations, and gets at the heart of the good. There is war which will give life, which will hold it and make of it a fine thing. Woman realises the essential unity of life, and her ideal is to make of it a harmonious whole. It is no idle dream, impossible of realisation; it only means the happy balancing of opposites. Though woman instinctively recoils from war that brings destruction to her great works of art—men, one need not fear that she will use any power she may get in the future in furthering mad schemes of disarmament, or that she will use her charms to enervate her mate and make him unfit to fight. Those days have passed, for woman can read history and understand; she can "see life steadily and see it whole." Though now her heart is aching with pity for the suffering of the men she made and for the loss of beautiful life, yet will she be ready to bless this war if so be that it bring men to "re-value their values." L. C. B.

Letters from Guy's Men on Active Service.

Belgian Field Hospital,
Field Post Office,
Dunkirk.
December 19th, 1914.

My Dear Saner,

I don't think I have written to anybody yet at Guy's since I have been out here—ten weeks on Monday. It seems months ago! I missed having a talk with you while I was in Town after our Antwerp experience. This has not been so exciting, but, nevertheless, just as interesting. We are situated about fifteen miles from Dunkirk, in a large Religious College. At first we found matters extremely difficult, as at Antwerp we did have a ready supply of electric light, gas, and water (the last only exists here and that is not too accessible!) Also, we had no surgical instruments of any sort, as they got lost in the transit (luckily some Belgian R.A.M.C. had had two cases). The first two weeks were a night-mare—there were three other surgeons attached to our party, and notwithstanding this we used to have as many as three tables going at a time in this small theatre, and working with oil lamps, often at 4 a.m. The wounded used to pour in, we have only three wards containing sixty altogether, and then we used to have to make straw mattresses on the floor or leave the patients on the stretchers in which they came. It was awful! The wounds have, all the way through, been more severe than me met in Antwerp, and chiefly due to shells. Limbs blown away or shattered, and heads. I think in two weeks we did nearly thirty amputations, there were not many abdomens. Except in very severe cases the patients seldom remained in here more than two nights, and then were hurried on to Dunkirk or Calais.

In the middle of the two weeks we all had to fly as bombardment was imminent. Lord, it was a scuffle and all a blunder. However, we soon got settled down again, and were full and overflowing in two days. I think we had been out here a month when Souttar returned. During the next four or five weeks we have been comparatively slack, except for one rush. The big cases Souttar always operated upon, he has done a number of platings, especially compound femurs; asepsis is out of the question. What the real results have been I don't think anyone can justly say, but three have really pleased me. The abdominals have been good. We generally leave an abdomen which has been shot high up, and consider an abdominal wound after twenty-four hours standing as a very bad job. Souttar likes to operate on all low abdominal wounds, especially in the first twenty-four hours. Funnily enough we have had a run of abdomens for the first time during this week. The worst cases are those which have been lying wounded in the trenches for more than twenty-four hours, and we often get them some perhaps as long as four days!! Their wounds smell horrible even though they may have had a dressing on, and we have had quite a few cases of rapid gaseous gangrene, twenty-four to thirty-six hours, and two cases of malignant œdema, dead in twelve hours.

We don't keep our cases long enough to see whether any of them develop tetanus—some of our present cases have been in quite a long time, but oh, it is weary work, and one longs for favourable conditions and surroundings. I think what worries me more than any other is the hopeless fact of not being able to speak to the patients or understand them. My French is a wee bit better, but I can't get it out! About three weeks ago we received a new boss, Perrin of the London, a friend of yours I think. He is complete boss and it is much more satisfactory, he seeing that we were slack has made us much more methodical and we now keep charts and sorts of notes over the beds, and our rotation of duty and take-in days is now strictly carried out. I think you would enjoy it. The party is jolly nice, and there are no limitations out of or even during work. Honestly, there is not much to do when off duty except an occasional motor ride, the country is filthy with mud for walking, which is limited to certain directions. Excuse the pencil please as my

pen has run dry. The operating theatre forms one of our sitting-rooms and it has a jolly good stove. You would laugh at our sleeping accommodation, it is a large dormitory with three rows of cubicles, the ladies sleep one side, we doctors, &c., in the middle, and the stretcher bearers, &c, down the third row. We have early tea brought to us and certain other attentions, in fact we are spoilt. Well, so long, with remembrances to all.—Yours sincerely, CHARLES F. PEDLEY.

We have now been eight weeks in Dunkirk, which has served as the main evacuation place for French wounded in the northern part of the fighting in Flanders.

On our arrival out here we were fully equipped for field ambulance work, which we had been led to suppose was terribly needed; this we found to be the case, but we also found that there was even more need for a stationary hospital, as the wounded were pouring in at the rate of nearly a thousand in twenty-four hours, and the French hospitals were absolutely full. The condition of the wounded was simply pitiable, and although the French authorities were doing their best, they were thoroughly unable to cope with the enormous demand on their rather small resources. To a certain extent they were not to blame for the conditions, as they had given Boulogne and its railway to the British, and Calais and its railway to the Belgians, so that the whole of their wounded had to be concentrated on Dunkirk.

We fixed on a Café by the sea shore, and this having been commandeered by the authorities we were in a few days doing our share of the work.

Every night since then we have had our motor ambulances and part of our staff at the station from about 9 p.m., when the trains begin to arrive, till the early hours of the morning. When we first started the station work, there was only straw on which the exhausted wounded were stretched, there were no facilities for washing, doing dressings (the atmoshpere almost prohibited his), or making hot drinks. The sight of those long goods sheds, packed like sardines with brave men, and the sounds, for the Frenchman is not a silent sufferer, were terrible. However, in a few days we had a part boarded off and fitted with hot and cold water for a dressing room, and with some large stoves fixed in the centre, we were able to prepare hot drinks, of which coffee and Horlicks Malted Milk were the most popular. The French medical staff there almost did not exist, and we decided to take any case which wanted either immediate operation or subsequent careful nursing. The minor cases, with their wounds dressed, were put back into the train and sent on either to the heart of France or by hospital ship to Cherbourg.

For nearly three weeks we were the only English Hospital there, though some dressers were sent out to assist in the station work. Since then, however, several more have arrived, and although there is plenty of work still, it is as usual after a rush, rather a case of being "embarras de richesse" as the French organisation has so improved. Luckily, we as the "old firm" are always full up, and our average of cases is about 75; of these practically all are French, though we occasionally find English who have lost their regiments. We also treated the wounded from the ships employed in the coast bombardment.

Unfortunately it is necessary to evacuate as soon as possible to make room for more serious cases, and so a great deal of the interest of watching the progress is missing though the variety of cases seen is greater. Our list of excitements is not a long one, three times German aeroplanes have dropped bombs on the town, with disastrous effects on the buildings, though the loss of life has luckily been small.

We have had two Germans, one only 17 years of age, who came to the station three weeks after their wounds had been inflicted. They were mere skeletons, and refused all drinks at first, evidently expecting poison. Later on they became extremely grateful and quite talkative and told us that the story of the mitrailleuse trained on them from behind was a fact. They appear to have been left on the no-mans land between the lines where with English and French wounded they managed to subsist in a farmhouse. They told a dreadful story of how the Germans occasionally came and took away the lightly wounded of their own race and of the Allies, and left all the badly wounded as being no further use for fighting, and difficult to move back to Germany, I heard exactly the same story from an Englishman with a compound Femur, who at length managed to crawl to the French lines.

Occasionally we get messages from the firing line saying that a batch of wounded are lying in a certain place. We then go out in our cars and pick them up. This can only be done at night without lights, and the men are either found in a cellar amongst the ruins of a village, or in a partially destroyed church. The journey back is terrible for some of those with fractures, but in many cases it is their only chance of getting treatment.

As regards treatment, the immediate is not in our province as we never get a patient whose wound has been inflicted less than twenty-four hours before admission. As all the wounds are septic, our treatment is to clean them, give good drainage, and pack with 2 % Iodine and gauze for twelve hours. This is then removed, and the wound irrigated with Peroxide as often as possible every day.

The greatest difficulty we have to deal with has been the treatment of compound fractures of the femur, especially those near the trochanters. The splint we have found most useful is the interrupted Liston, with the iron projection graduated for the different position of the wound. The patient can be turned over on these and washed and dressed without very much pain, and although there is no continuous extension, the treatment of the wound is the most important thing, and when this is cleaner and his general resistance to the infection secured, we have to evacuate him. As regards plating, the results I have seen have not been very striking

except that the nursing is made so very much easier. This in some cases is of great importance, as the twice daily painful dressing is apt to use up a patients strength. We had a great number of cases of gangrene, not the rapid but the slow form, and in nearly every case I feel certain that the cause was not the wound or the infection, but the bandage. This is applied in the trench or first dressing station, tight, to avert hæmorrhage, and it is sometimes days before it can be changed. The wounded part swells and the bandage becomes a tourniquet and gangrene sets in below. In many cases the wound has been quite trivial and not very septic.

The chest cases do very well in our sea air, and they seem to acquire a protective rigidity of the chest wall to promote the formation of adhesions, analagous to the peritioneal rigidity in abdominal conditions.

There have been nine cases of tetanus, seven of which have developed in under seven days after the wound. We are treating them with chloretone in large doses per rectum and injections of carbolic, so far without success. The serum we are using entirely for prophylaxis, as the opinion seems universal that it does no good when the symptoms have set in. The chloretone has in every case worked splendidly, and the spasms have been completely controlled in every case, giving great relief to the patient.

We hope to move along the coast to another place, when the allied advance makes this possible.—Yours sincerely, O. G. M.

From H. W. K. Fry, M.O. 1st Battalion Royal Welsh Fusiliers, Expeditionary Force.

Dear Bull,

Have just got your letter dated October 24th. I left the General Hospital when the other dental men came out, asked for a regiment, and have got it. If only I could tell you half the things I have been through it would make you think what a lucky man I am to be here without a scratch up to now—December 12th. I was all through the battle of Ypres, October 19th to November 14th. We lost, — men and - officers during the first fortnight. Our ambulance was stationed in the town, which was shelled for hours on end. Good heavens, what a sight! . . . . . When we left the town it was all in flames. What a grand sight, and one which I shall never forget. We marched two miles with shells bursting all around us. We are now in a different place; I live in a dugout 350 yards behind the trenches, which I visit night and morning. Our trenches are only 250—300 yards from the devils, and we can see their trenches easily, and the smoke from their fires. Trench life is grand except for lice; fancy a man used to his daily morning bath at home, now sitting scratching hard. But there, you cannot help it. It is all very well in theory talking about how to avoid it, but you cannot. Shells are not so plentiful here, but they have got some really good shots, and every time you expose your head they get a bull; poor devils, the last six men killed here have had their brains knocked out.

Am still worrying over pyorrhœa, even out here the bully beef plays the deuce with our gums. We have been reinforced again so have — men to look after. My fittings here are extremely temporary, extractions take the first place, and I do them for the other regiments on our left or right.

Am always glad to have news of the hospital. By the way, many congratulations; we shall have a feast if I get back safely.

I have plenty of souvenirs if I can get them home. Of course, I enjoy this life, because I feel that at last I am doing my duty: I take pride in getting iodine on to a wound, and especially around it, as soon as possible. The life has its drawbacks—the frost, the snow, the rain, and, worst of all, the mud—really in parts it is up to one's knees, without any exaggeration.

Am writing this in an officer's dugout in the advance trenches, only 250 yards from the devils, as I am staying the night up here because some of the men are going out to get some prisoners. We want to know who they are and how many, so I may be wanted.

Good luck! Excuse writing, hope you can read it.

W. K. FRY.

Ward Concerts.

CLINICAL.

Overheard in Clinical: "I say, Bill, that's what I call a real concert." Bill: "Real fine I calls it, too."

This practically sums up the clinical concert. We spent a most delightful afternoon and were singularly fortunate in having such a group of talented artistes. There was not a dull moment, and everything went with a genuine Christmas swing from start to finish. Mr and Miss Pinder gave us some very fine songs, and were extremely amusing in duet. Mrs Enid Hawksley's Pierette troupe (Misses Dickens, Roche, Russell, and Marshall) looked most charming in their patriotic pierette costumes and gave us, both individually and collectively, some very pretty songs and lively choruses. Mr. Roche gave two capital comic songs and caused much merriment. Mr. Muir-Smith and Mr. Groves rendered their classic "Out in the open," and favoured us with a special verse. Mr. Seabrooke, with his usual kindness, gave us two excellent songs. Between the performances in John and Miriam, tea was very kindly provided by Sister and the nurses. We cannot close without one more word of thanks to the friends who so royally entertained us

BRIGHT.

A concert was held in Bright ward on Wednesday, December 30th, and was unanimously declared by the patients and their friends to have been most enjoyable. Our best thanks are due to Mrs. Balsdon for the great assistance she rendered by bringing a party of talented

singers who worked untiringly for our pleasure throughout the afternoon. The songs given by Mr. Bentley, accompanied by himself on the guitar, were awarded loud applause. "Local talent" was splendidly represented by Nurse Tyler Cove, Nurse Macrone, Messrs. E. D. Scott, H. N. Eccles and H. L. Attwater. Mrs. MacLeod and Mr. R. Curle very kindly accompanied at the piano.

We must take this opportunity of offering our sincere thanks to Mr. Geoffrey Seabrooke for singing in the ward during Christmas week.

NAAMAN,

The Naaman Concert was held this year on Monday, December 28th, and was declared by all who heard it, to be an immense success. As the afternoon went on the audience increased till the ward was as full as it could be. Mr. Harry Hughes opened with some delightful songs, followed by two duets with Miss Nancy Turner. Mrs. Kenneth Douglas, who had come in Mr. Rowlands' party, gave a stirring recitation of Kipling's "If," and Miss Esme Berringer's two recitations were most enthusiastically received, Miss Phyllis Lett, who was performing at another concert, kindly came and sang twice to us. A one-act play by Mrs. and Miss Turner, songs by Mrs. New and by Miss Lane, dances by the Misses Woolnoth, patter songs by Mr. Bernard Davis, and Mr. Hirsch's Jewish impersonation all went to the make up of a most enjoyable afternoon. Mr. Kennedy and Mr. Davis accompanied between them most of the items, and Messrs. Muir-Smith and Groves' duet provided a rollicking wind-up to the entertainment.

DORCAS.

A most successful concert was held in Dorcas on Tuesday, December 29th. Madame Bassien, Miss Marjorie Phillips, Mrs. New, and Miss Edith Hearne all sang to everyone's delight. Recitations, humorous, from Miss Winter, serious from Mr. Frank Lindo, and some most charming dances by Miss Duncan came between the songs Miss Mitchell combined song and dance in her much appreciated rendering of Gwendolen Brogden's recruiting song, while the ever-popular Lieut. Seabrooke and Mr. H. Q. F. Thompson supplied the male voices. Mr. Myers proved himself throughout the afternoon the perfect accompanist.

QUEEN VICTORIA.

The patients in Queen Victoria Ward each invited one friend to tea and a concert in the ward, on Tuesday, December 29th. The concert was entirely impromptu, but it was most successful and much appreciated by everyone. Miss Bird, Miss Bateman, Miss Fischel, Miss Mitchell, Miss Elsie Hinds, Mr. Geoffrey Seabrooke and Dr. Gibson were among the performers, and gave many patriotic and popular songs which delighted the audience.

CORNELIUS.

This entertainment was held on December 28th for the patients and their friends. As all Corney Concerts are, this year was no exception in its excellency. With such artists as Miss Bateman, who is a new friend to Guy's this Christmas, and Mr. Seabrooke's brother, whom most present Guyites know of old, a sure success is ensured, added to which Miss Fischel rendered two songs in an excellent manner, especially "The Little Grey Home in the West." Mr. Philip Scott brought some friends whose items met with a great reception, only to be repeated when Mr. Sells (late of the Niggers) gave us some of his very best; we only wish we could have heard more of him. He was ably assisted by a chorus of late Niggers. The concert was continued by others up to the end, and we most heartily congratulate Sister on her Entertainment.

EVELYN.

On viewing the Programme of Concerts for Boxing Day, one could not help being attracted by the poster announcing the above entertainment. Punctual to the hour the programme was started by H. N. E. with one of his well-known comic songs, and the items followed in quick succession. Miss Fischel, Miss Oram, Miss Messinger, and Miss Bateman all receiving a great reception from our future heroes and their assembled friends. The latter lady in her Scotch stories greatly touched the heart of a late Scotchman whom we saw on Christmas Day. Following these individual items, Mr. Wright's party of ladies gave us some good turns, as they did last year. But perhaps the great feature of the afternoon was the arrival of Mr. Saner's party of friends: Mrs. F. S. Saner, Miss Turner, Miss Mitchell, and Mons. Garton. The dance by the last lady and gentleman, also Miss Mitchell's Recruiting Song, being most popular. Later on, after the tea interval, one or two of the "Nigger Brigade" made merry to the ring down of the curtain. Sister Evelyn and Mr. Danby are to be congratulated on their variety of turns and the excellence of the concert.

JOB.

On Monday, December 28th, a most successful concert was held in Job Ward. Many willing friends gave us a splendid programme, and led by Miss Phyllis Lett the concert filled both patients and visitors alike with the joyful feeling of Christmas. Our best thanks and gratitude to those who so kindly helped us.

LYDIA.

On Tuesday, December 29th, a "children's party" was given in Lydia Ward. The delight of the children at the antics of Mr. Punch was unbounded, especially when he became warlike towards Judy and other mem-

bers of the caste! The laughter and joy of the children must have conveyed their thanks to Mr. and Mrs. Steward for sending such fun to the Ward. Father Christmas appeared as usual and as the result of his visit the noise of "musical instruments" was heard in every ward till bedtime.

CHARITY.

This concert was held on December 29th, the patients having their friends and the back ward being filled by the men of Luke ward. This year there was no Magic Well or Father Christmas, but the standard of artistes left nothing to be desired. Mr. Sheldon, late of the ward, rendered the Floral Dance in an excellent manner, being ably accompanied by Mr. Stirling Hill, who, whenever possible, has devoted his excellent abilities to the success of our Christmas entertainments. Miss Fischel and Miss Bateman again gave us some top-hole songs and recitations at the piano, and in addition to these we had the pleasure of hearing Mr. Godfrey Tearle read a passage from Kipling and afterwards recite. Miss Mitchell also rendered her great success, The ? Song, and Mr. Seabrooke's items met with their deserved applause. Amongst others of our local talent, Mr. Thompson and Mr. Eccles further enhanced their reputation. In fact, Charity's concert stands out as of old as being one of the best, and every congratulation is due to Sister and Mr. Danby, the organisers.

Vignettes from France

III.

OTHER troops had come in to take the place in the trenches of the brigade to which we were attached, and we were moving back a few miles to take a short rest. Part of the ambulance had safely reached the top of a short rise, but one of the heavy waggons stuck half way up, and the rest of us halted at the top while extra horses were sent back to help the waggon still on the hill. On the right we could see a supply train moving down into the valley we had just left, and two aeroplanes were returning to their park after having made the evening reconnaissance.

To our left and in front the plateau continued almost flat, broken here and there by haystacks which the Germans had neglected to burn in their retreat. Some little way in front of us, on either side of the road, were two blackened patches, and, having nothing better to do, we rode on to examine them. The patch on the right of the road was reached first, and proved to be the remains of a haystack where the Germans had burnt some saddles. The heap on the left was larger, and consisted of the remains of a large open shed which had been used to store hay and straw.

Corrugated iron was lying on the edges of the burnt patch and had evidently been piled against the side to make a draught for the fire.

On coming up close we could see that some of the ash was a very light colour. This decided us to look more closely. On the side nearest the wood there was very little to see except that some of the ash was light and some dark, but on the farther side, where combustion had not been complete, appearances were quite different. Someone had raked this side fairly thoroughly and had collected heaps of human bones of every description. For some reason clavicles and ribs seemed to predominate, and, except that there were no skulls evident, nor many of the small bones of the hand, every bone of the body was there. We had found a German crematorium!

Shortly afterwards we left the charred remains to rejoin our ambulance which was again on the move.

H. C. R.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Florence Nightingale to her Nurses. (Macmillan & Co., Ltd.) Price 1s.

Nurses will enjoy this little book of addresses, written by Miss Nightingale to her probationers during a period of twenty-eight years. With all her practical advice, and pleasant reminiscence, she points out the high path and exalted ideal of service of which her life was the illustration. The simple language of the early addresses reminds us of the scanty education possessed by most nurses at that time.

Sciatica. By William Bruce (Baillière, Tindall & Cox,) 1913. Crown 8vo. Pages xii.—175. Plates, 18. Price, 5/- nett.

Dr. Bruce believes that Sciatica as a disease does not exist; in other words, that all diseases called by this name are really due to osteo-arthritis of the hip. No doubt he has done valuable work in calling attention to the fact that many cases of Sciatica may be explained in this way, but his doctrine is surely going a good deal too far. The book represents the observations of a lifetime, so that obviously there is very little direct evidence given from radiographic examination. This is a pity, as there is no doubt that this affords direct positive evidence on the subject.

There is another criticism to find. The subject is too drawn out. It would have been treated more suitably in an article in one of the medical journals. Still, this book is refreshingly written, and one must admire the wealth of detail, and pains taken.

Medical Nursing. By A. S. Woodwark, M.D. (Edward Arnold, London.) Price 4s. 6d. net.

Evidently intended primarily for nurses, this book is thoroughly up to date, and should be of value both to the trained nurse and to the novice. It is clearly and concisely written, and the details concerning the nursing treatment of each disease are so arranged that they can be seen almost at a glance. There is an excellent chapter on invalid cookery, and the rudimentary principles of massage are dealt with as adequately as the limited space allows.

Buchanan's Anatomy. (Baillière, Tindall & Cox.) Second edition. Price 21s. net.

This book comprises in one volume Practical Anatomy and Systematic Anatomy, which renders it exceptionally useful both to the student and to the practitioner.

The old nomenclature is adhered to throughout, and in this respect the publication remains unique. There can be no doubt that the old nomenclature is regarded with greater favour by students of anatomy and their teachers. For the practitioner, or surgeon, it is almost essential that an up-to-date text-book in the old terminology should exist, and this volume provides for this necessity, a necessity which is apparently lost sight of by so many authors and publishers at the present time. The various subjects are well arranged and concisely described, and many instructive drawings (most coloured) accompany the descriptions.

The subject of development is appropriately dealt with at the conclusion of the description of each viscus or organ. Such a method of dealing with this important branch of the anatomy imparts very considerable interest. The whole book is thoroughly recommended as a complete and interesting study of the subject of anatomy.

Physiological Principles in Treatment. By W. Langdon Brown. Baillière Tindall & Cox. Third Edition, 1914. Crown 8vo. Price 5s. net.

This is a most excellent little book of some 400 pages. It should be read with interest and profit by practitioners and students alike. It is particularly suitable for men just qualified and holding hospital appointments.

The style of the book is clear, and the opinions of the author not expressed in too dogmatic a fashion. How often does one read a book of this kind and wonder whether the statements so dogmatically expressed are really facts. This book at any rate has the great advantage that it is provided with an excellent bibliography, and that doubtful statements can, if desired, be traced to their source by the reader himself.

In one point the reader is left in doubt. The acidosis in diabetes is compared with the acidosis for lack of oxygen. The great dissimilarity of the two conditions, viz , that there is acetonuria in one case but not in another is not mentioned. Again, in diabetic coma it is suggested that the body has difficulty in getting rid of CO_2, but surely recent work is quite at variance with such a view.

Public Health Laboratory Work. By H. E. Kenwood, M.B., F.R.S.E. Sixth edition, demy 8vo., xi. 412. (H. K. Lewis). Price 10s.

The advent of a new edition of Professor Kenwood's well-known volume "Public Health Laboratory Work" is of great importance, and the author has recognised the necessity of treating the chemical work as a separate entity. We regret to note, however, the omission of several tests, and this is unfortunate, because a student in Public Health surely needs information on more than one or two isolated methods of identification or estimation. As instances of this we would point out the following:—Hehner's method for estimating hardness in water; Griess' method for "detecting" nitrites; and the Indigo method for estimating nitrites and nitrates. In regard to the Hehner method, this is quite simple, and moreover gives very good and concordant results, whereas, in Clark's soap method it is known that the calcium and magnesium salts present in a sample do not combine with the "theoretical" amount of soap solution. It would have been well to mention this, and point out the relative merits and demerits of the two methods.

In a former edition, the quantitative estimation described for determining nitrites was Griess' μ phenylenediamine method. In the present volume this has given place to Ilosvay's α naphthylamine method, and the latter is certainly much more sensitive (50 times); but, we think it would have been advisable to mention briefly the former method instead of deleting it altogether. Furthermore, since there are two naphthylamines (α and β) it would have been better to point out the use of the α derivative here (p. 95) instead of doing so much later on (p. 270). Incidently, we may note that the β derivative gives an orange colour, but the reaction is not so sensitive.

The author describes the preparation of "standard potassium nitrite" by using silver nitrite and potassium chloride. It is time this this method was changed, because silver nitrite is not easy to dissolve even in boiling water. A marked advantage is gained by using barium nitrite $Ba(NO_2)_2 \cdot H_2O$ (a salt which can be obtained quite pure and is freely soluble in cold water) and precipitating the barium with potassium sulphate. The use of barium nitrite for preparing nitrites of the alkali metals was recently described by Ball and Abram (*Journ. Chem. Soc.*, 1913, **104**, 2130).

In estimating "nitrites and nitrates," the Indigo method is not mentioned, but perhaps it has fallen into comparative disuse. If, however, the Indigo solution is fresh, the estimation can be carried out with a fair degree of accuracy, and, moreover, the determination is rapid.

The yellow colour obtained in estimating "nitrates" by the Phenolsulphonic acid method is described as being due to "potassium nitrophenol sulphonate" (p. 99). The usual idea is that picric acid is formed and the ammonia used converts this into ammonium picrate which possesses an intense yellow colour. If, as the author states, a potassium salt is formed, then potassium hydroxide would be used instead of ammonium hydroxide. Indeed, on p. 141, this method is referred to as the "picric acid process."

The illustration of Wanklyn's process on p. 79—which occupies a whole page— might be much improved. The condenser is an old pattern, and we are of opinion that a "trap" is very desirable between the flask and condenser.

The volume is clearly printed and the descriptions of the various processes are concise and easy to follow. The section on food is an admirable exposition of the subject, and should prove a valuable aid to the Public Health worker and student. We repeat, however, that it would have been desirable to include some processes which are by no means obsolete.

The fifth edition of Luff and Candy's *Manual of Chemistry*, revised and enlarged by Mr. Candy, is announced for immediate publication by Messrs. Cassell & Co., Ltd. Much of the additional matter relates to the theory of ionization and some of its consequences. Typical instances of the law of mass action and its relation to chemical equilibrium are also discussed at some length. The section on volumetric analysis has now been extended to include the volumetric aqueous solutions of the new British Pharmacopœia.

Diseases of the Ear, Nose, and Throat. By George Nixon Biggs. (Published for the University of London Press, Ltd., by Hodder and Stoughton.) Price 10s. 6d. net.

We have seldom met with such careful attention to detail as is shown in this book, in which the author has risked the accusation of repetition in order to make every point clear.

For this reason we can recommend the book as being a clear and concise account of routine methods of examination, diagnosis, and treatment. It is refreshing to find a book on this subject which does not give an elaborate anatomical description, and the author's diagrams, upon which he relies a good deal, serve well to illustrate his remarks. We would here suggest that in these days of perfected colour printing the addition of a few plates in natural colours would increase considerably the value of the book, for in this subject colour plays an all important part.

The preface disarms the critic at once, for the author sets out refusing to discuss debatable points. There are, however, certain statements upon which one must comment. Congratulations are due to Mr. Biggs on boldly casting his lot with the rising generation in definitely plumping for direct methods in laryngeal operative work, and braving the ire of the great experts and champions of the indirect method. We were, however, surprised to read such a curt dismissal of Barany's suggestive tests as being of no clinical value.

It is interesting to note that the author discards Schwartze's operation in favour of meatal drainage through an incised membrane with closure of the post-auricular wound—and the main reason put forward is the possibility of stenosis of the meatus after a Schwartze. It seems very doubtful whether it is worth while to jeopardise the drainage in order to avoid a complication which, according to experience at this hospital, hardly ever occurs.

Other points on which our routine differs from that advised are of minor importance. The comparison of the patient's bone conduction with that of the observer has been abandoned here, and the use of a fork, whose amplitude can be standardised, has been substituted.

The Studer principle in Tonsillectomy is entirely ignored, but we have found it more efficient and more easily taught and mastered than the Mackenzie method which the author advocates.

We notice that the author has chosen Lake as his chief authority in clinical Otology, and throughout the book Mr. Briggs follows closely that Surgeon's methods and views, though in advising Lake's operation for vertigo in cases in which the hearing is good, he goes distinctly beyond the indications given by the originator of the operation.

On the whole we recommend the book to those for whom the author writes it. It is well printed, of convenient form, and above all eminently concise and practical.

Births.

FELTON.—On December 11th, 1914, at Sooke, Vancouver Island, British Columbia, the wife (Sister Rennie) of Richard Felton, M.B., B.S. Lond., of a son.

BENETT.—On December 30th, 1914, at Trelaske, Dallington, Northampton, Maude Elizabeth, the wife of Capt. A. M. Benett, R.A.M.C., of a son.

GARDINER.—On December 23rd, 1914, at 60, Rotherwick Road, N.W., to Mr. and Mrs. Harold Gardiner, a daughter.

Deaths.

HENSON.—S. B. Henson, 2nd Lieutenant, Somerset Light Infantry (late Colonial Police, Penang), killed in action, December 19th, 1914, son of Dr. and Mrs. W. J. Henson, Wedmore, Somerset, aged 27.

BREDIN.—On the 9th January, at Orotava, Teneriffe, Richard Bredin, M.D., in his 58th year.

W. E. T.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE unsatisfactory condition of our soldiers' teeth is a subject to which much attention has recently been given. Up to the present time no provision has been available whereby soldiers whose teeth become decayed whilst in the service can get appropriate treatment. They must either leave the Army or get on as well, or badly, as possible without teeth. Several cases have come under our notice in which soldiers have returned from the front—some without any teeth at all, and others having no back teeth with which to masticate their food. Again, it is very annoying for officers to find that after they have trained recruits for five months or more, the medical officer rejects them for foreign service because of the condition of their mouths. Thanks to a generous donation, the Hospital is now able to help remedy this serious defect. The Commercial Union Assurance Company, as trustees and executors of the will of the late Sir William Dunn, have made a grant of £1,000 to the Guy's Hospital Dental Department to be used for the free dental treatment of soldiers below the rank of sergeant, on active service, and attested recruits. The help of old Guy's men has been invoked for the conservative work. Extractions will be performed by the Dental House Officers, and an extra mechanic has been engaged for the denture work. Special charts have been printed and arrangements have been made to see twenty new cases every day.

Quite recently Major Layton sent 100 R.A.M.C. orderlies from the base hospital at Chelsea to have their teeth attended to at hospital rates, paid for by the War Office. On an average three teeth per man were extracted and 200 fillings were done.

It will be recalled that after the outbreak of the war an offer was made by the School to the War Office to provide free dental treatment for all who were rejected as recruits on account of dental incapacity. In consequence of the generosity with which old Guy's men then proffered their services, the School was enabled to make very complete arrangements to carry out the work on a large scale. When, however, the scheme was put into effect it was found that the number of rejected recruits applying for treatment was comparatively small and so variable that the School hesitated to avail itself of the offer of old Guy's students, until it became apparent that their services could be used with some degree of regularity. This condition has now been met, for, by the generosity of the Commercial Union Assurance Company an extension of the scope of the work, formerly rendered impossible on account of the expense involved, will secure the regular attendance at Guy's Hospital of men sent by arrangement and under escort from the various Hospitals and Training Camps, and elsewhere.

The Dental Staff earnestly hope that it may be convenient for old Guy's men to renew the kind offer which they made in August last, and

undertake work in the Conservation Room on one half-day or more a week. If this is possible will old Guy's men indicate to the Dean the hours and day of the week which they prefer?

It is thought that the afternoon, between the hours of two and six, will be most convenient to those who offer their services, and that volunteers will prefer to bring their own instruments.

THE work of the Massage Department is now in full swing. The rooms above the Medical Wards are now completely equipped, and look very nice. Sister Massage has started a gymnastic class for educational purposes, Nurses and anyone else interested are invited; a fee of 5s. for a six months' course is charged, and a rubber floor is to be bought when sufficient money has accumulated from this source. Heart cases from Out-Patients and the wards are to be treated with graduated exercises, and research is being conducted on the effect of exercise on weak hearts.

Drs. Pembrey and Poulton, in conjunction with Dr. Cameron, are investigating the respiratory exchange of babies; the baby room above Clinical is full of weird and wonderful apparatus for this purpose. The Bacteriological Department is very nearly complete, and Dr. Eyre will take over the new premises early next month.

Only those who have been intimately acquainted with Guy's during the last 20 years can fully appreciate the great improvements made in the Hospital during that time. A large amount of money has been spent, and results have more than justified this expenditure. Two more additions will soon be completed: A new Orthopædic Out-Patients and a special Department for Tuberculosis, with separate access and waiting room for patients. The latter is most urgently required. Experience as an Out-Patient Officer shows that the treatment of patients with phthisis at Medical Out-Patients is most unsatisfactory. Very few patients can get the Sanatorium benefit, and if they do get it, they rarely stay in a Sanatorium longer than three weeks. These cases should be followed up in their own homes by special nurses. The New Department will not be a Tuberculosis Dispensary. It will be open to patients without restriction of area, in the same way as the other Out-Patient Departments, with a view to elaborate methods of diagnosis and treatment.

It is obvious that such a Department will afford particular facilities for local needs as regards Southwark and Bermondsey, from which neighbouring Boroughs a Tuberculosis Department at Guy's will serve for cases in which it is desired to obtain a diagnosis based upon the most complete methods of clinical investigation, and for cases where new methods of treatment may be applicable which the local Dispensaries are not yet equipped to provide. It has not yet been decided who shall take charge of this new Department, or how many days a week it will open. An experienced Tuberculosis Officer may be appointed, or on the other hand a member of the School Staff, for example a Demonstrator of Physiology, with the status of an Assistant Physician, may take charge of the Department and pursue research on phthisis, bronchitis, emphysema, etc., and ultimately become a specialist in diseases of the chest.

SIR JOHN BROMLEY died very suddenly in Bright Ward on January 14th. We take this opportunity to express our sincere condolences to Mr. Lancelot Bromley in his great loss.

AFTER a long absence through illness, Sister Addison is again at the Hospital. We wish her a very hearty welcome on her return.

THE sale of Christmas Greeting and Post Cards last year realised a total of £20 10s. 6d., £2 8s. 8d. more than in 1913. This shows that the new design of the cards was very much appreciated, for we must confess that we expected a smaller sale owing to the war and the absence of so many men abroad.

As in previous years Messrs. Ash & Co., Ltd., very generously supplied the Cards free of charge, with the result that the whole of this sum reverts to the funds of the Hospital. Thanks to the kindness of Messrs. Ash, and the loyalty of the nurses and men, the Hospital receives a very acceptable New Year Gift.

IN last week's issue of the *Lancet* there appeared a description of the Princess Christian Motor Bacteriological Laboratory now at the front. You will be interested to hear that this Laboratory is in charge of Capt. A. C. H. Gray, an old Guy's man.

DR. A. WOLF will deliver three public lectures on "The Philosophy of Nietzsche" at University College, London, on Thursdays, February 4th, 11th, and 18th, at 5.15 p.m. Admission is free, and those who require tickets should make application accompanied by a stamped addressed envelope to Walter W. Seton, M.A., Secretary, University College, London.

THE lighter side of life is very welcome in these days of hard work. We have asked an expert in obstetrics to answer Dr. Walker's amusing letter published in this issue.

MILITARISM is exerting a warlike influence in the Borough. We saw a letter in the College this week addressed *to the House Sergeant.*

THE other day two boys were waiting outside the Back Surgery. One was taking up rather too much room; the other boy said "If yer shove up agin me, I'll hit yer habscess open for yer."

THE incident happened in one of our Territorial camps. All those who wished to be "inoculated" were requested to see the doctor at 10 a.m. At the appointed hour not a man had come forward. Shortly afterwards, however, one budding recruit stepped forward, and the operation was successfully performed. "You can have two days' leave to recuperate," said the doctor. The news spread, and within half-an-hour there was a queue formed in front of the doctor's quarters waiting to be inoculated.

WE drew the attention of past and present students, in our last issue, to the fact that a fund has been started in aid of Mr. W. J. Flint, who has had to resign his post owing to ill-health. May we ask all to contribute as soon as possible as we know there are very many who are willing to subscribe. Contributions, however small, will be gratefully received, and should be sent to the Secretary of the Dental Society, Mr. W. J. Rousseau Viljoen, at the Hospital.

The next meeting of the Dental Society will be held on Tuesday, 2nd of February, at 5 p.m. There will be no paper, but a discussion on "The respective merits of bridgework and partial dentures." This ought to be exceedingly interesting, and we trust that a good number will turn up. Tea will be served at 4.45 p.m. "Some" discussion!

Obituary.

ALEXANDER LINDSAY FITZMAURICE, M.B., B.S. Lond.
Colonial Medical Service.

WE regret to announce the death of A. L. Fitzmaurice, which took place in Somaliland.

Born on April 18th, 1885, he was educated at Belvedere School, Hayward's Heath, and matriculated into London University in June, 1903. He entered Guy's in October of the same year and passed the Final Conjoint in 1909. He held various house appointments, being A.H.S. to Mr. Fagge from January to June, 1910, and H.P. to Dr. Shaw from July to December. As a resident he gained much appreciation as an anæsthetist, and his popularity with his colleagues was such that he became Vice-President of the Residents.

In February, 1911, he went to the Bagthorpe Infirmary, Nottingham, where he remained for about eighteen months. He next held an appointment at the South Eastern Hospital, New Cross, from August, 1912, till early in 1914. He took the M.B., B.S. degree in May, 1913. After a course at the London School of Tropical Medicine, he joined the Colonial Medical Service and left England for Berbera, British Somaliland, on April 30th last. The date and circumstances of his death are not yet known; the last letter received was written from Burao, where he had been attending to Indian troops wounded in the recent fighting in the interior of the Somaliland Protectorate. He was then in the best of health and spirits.

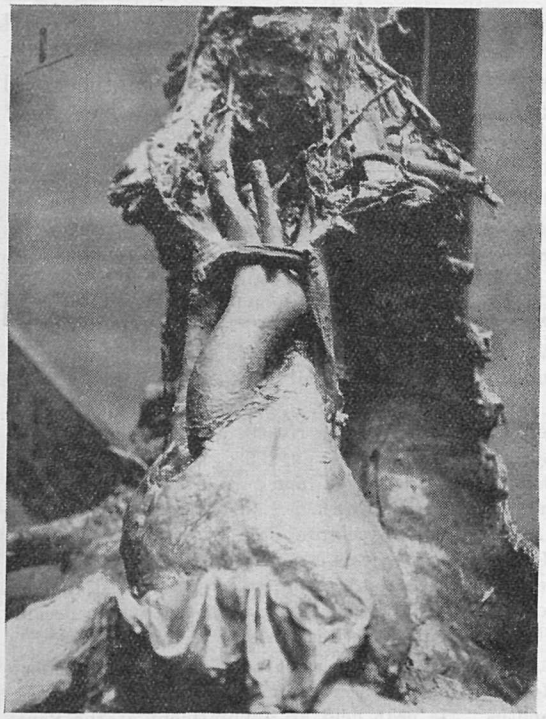
He always used to say that the happiest years of his life were spent at Guy's. Now he is gone! But the memory of "Fitz" will live for many years in the hearts of those who knew him and were privileged to work with him.

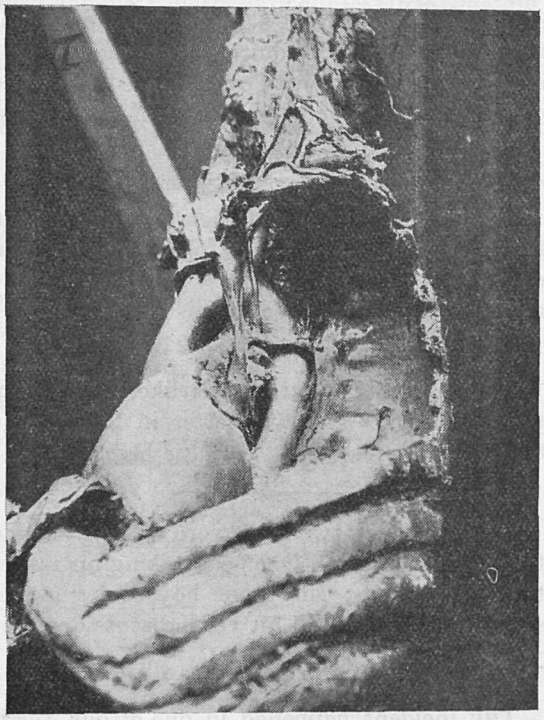
"'Tis not the whole of life to live
Nor all of death to die."

W. E. T.

A Left Superior Vena Cava.

THE photos show a very symmetrical arrangement of the veins draining the upper part of the body. This is due to the left Cuvierian duct of the embryo having developed like the right instead of undergoing atrophy and becoming the usual Vein of Marshall, which runs obliquely downwards and to the right on the posterior aspect of the left auricle.





The first photo shows the two superior venæ cavæ joined across by a vein which represents the left vena anonyma of the normal subject. In cross section the latter vein was about half the lumen of the right innominate.

Whether this is due to the presence of a left superior vena cava or the development of a left S.V.C. was brought about by the partial atrophy of the left S.V.C. is a difficult matter to decide upon. One would, however, be rather inclined to adopt the latter view because we are so accustomed to see animals developing in what we term the normal manner.

The second photo shows the abnormal vena cava opening into, or, to be more accurate, becoming the coronary sinus. Across the arch of the aorta is seen the vena hemiazygos bearing exactly the same relations to the left S.V.C. as the vena azygos does to the right S.V.C. Further, the left superior intercostal opened into the vena hemiazygos. The vena hemiazygos accesarius opened into the vena hemiazygos. In the abdomen the subject showed the presence of a Meckel's diverticulum, about two inches long, which was situated two and a half feet from the ilio-cæcal valve. The man was a lunatic, aged seventy-three.

RAOUL LE BLANC.

Guy's,
December 30th, 1914.

Change of Address.

Lieut. C. de W. Gibb, R.A.M.C. (S.R.), R.A.M.C. Training Centre, Eastbourne.

Dr. H. J. Hoby, 219, New Road, Chatham, Kent.

Lieut. J. A. Ryle, R.A.M.C. (S.R.), No. 6 Camp, No. 1 Base, British Expeditionary Force, France.

W. Beresford Robinson, M.B., B.S. (formerly William Robinson), Down House, Sutton, Surrey (*Phone*, Sutton P.O. 401).

Capt. M. A. Rahman, I.M.S., c/o Messrs. Grindlay, Groom & Co., 54, Parliament Street, S.W.

(The Editor will be very glad to receive a post card with notes of any change of address.)

The Log of the "Glengorm Castle"!

(Continued)

Saturday, October 24th.—We learn that the *Gilford Castle* has been rammed by the *Carisbrooke Castle* just outside the harbour. *Gilford* was at anchor so could not possibly be blamed. Bibby liner *Oxfordshire* just docked astern of us, and is loading up fast with British wounded. They have just sent down from the "firing line" for a colossal amount of ammunition—the biggest order for one day yet recorded during the campaign. The Germans are trying to push through to the coast again between Dunkerque and La Bassée—in fact, all along the line a tremendous assault is being made. A great number of badly wounded men from the front to-night. They say the French and the Scots are "taking no prisoners!" Sent 16 men ashore to help carry wounded.

5.15 p.m.—*T. B. Durandel* comes into basin and succeeds in fouling a buoy! No signs of the Staff coming yet from Marseilles.

Sunday, 25th.—Up 7.30 a.m., wind S.W., sunny and warm. No war news. Two submarines gone out with torpedo boat destroyer. Saw 1,100 wounded aboard the *Asturias*. All very comfortable and clean. Some German prisoners, having far too good a time. Met three Belgians on the pier and had a long yarn with them. All convinced that the war will be over in a couple of months in favour of the allies. Broke another cable to-day whilst we were "tying-up," but as there is a 25 foot tide here it is not surprising. There are 1,500 Indian wounded on their way to Boulogne from the front, so we shall soon be at it now. Our orders are to stay here as a hospital base as there is no place ready for Indian wounded at home. May have to stay for three weeks or a month. Fearful fighting still along the coast. Enemies casualties estimated at 3–1 of our own by competent observers. Ours are put at 9,000 during the past 7 days. The worst fighting yet recorded. *H.M.S. Badger* has rammed a German submarine. Col. Prall's son is acting as surgeon-probationer aboard her. Great rejoicings and slight celebrations. Wind cold, S.E. Rain storms. Weather looks bad. Glass falling.

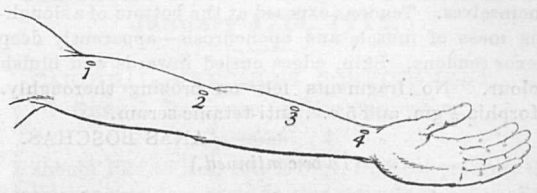
Monday, October 26th, 3 a.m.—Indians reported arriving. Wait till breakfast and none appear. We do a little "jetty-jaunting" and move from our old position further down the quay to be nearer the ambulances. On our way we nearly ram the gallant *Escopette*, a minute French T.B.D. who's skipper dances impotently as our massive stem overhangs his counter. We eventually bring up about ten feet above him!

9 a.m.—Frenzy of cutting up gauze and H.B.F.'s boric lotion, etc. Whilst in the middle of this occupation the wounded arrive. Nearly all shrapnel wounds. They say they have been in trenches at 500 yards from the enemy. They took 500 Germans and 7 machine guns.

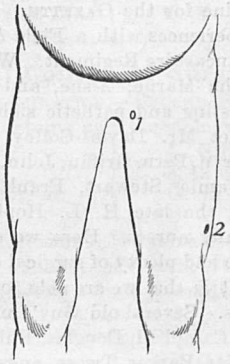
CASES.

I. Bullet-wound of left hand. Entered dorsum near centre. Hole about the size of a pea. Clean-cut edge. Bluish colour. Exit on palmar surface size of 5s. piece. Ragged. 2nd metacarpal shattered.

II. Four bullet wounds in the left arm as indicated. Beyond some soreness, nothing else manifested. Pronation and supination perfect. Flexion and extension



at the elbow-joint perfect. Same case had a bullet wound in the groin which was quite remarkable. The bullet traversed Scarpas Triangle and passing through the thigh, missed the femur and appeared on the outer side of the thigh, about the lower third, and in such a position that it must, of necessity, have shaved Hunter's canal. No hæmorrhage or aneurism, fracture, or paralysis. Gave this man 5 c.c. anti-tetanic serum (7,500 million).



We had a surprise visit from the Queen of Portugal this afternoon, who took great interest in the men and their welfare, and made a thorough inspection of the ship, showing keen interest in everything.

III. Bullet-wound lower end of left fore-arm just above the wrist on ventral surface. Emerged on dorsal surface slightly lower down. Joint not involved. Lower end of radius and ulna completely shattered and comminuted. Size of 5s. piece. Some "fraying" of superficial flexor-tendons which lay on the ragged exposed exit surface. The edges were characteristically curled inwards. Much pain and extensive teno-synovitis and cellulitis spreading up forearm. Amputated at seat of election. Wound caused by rifle-bullet fired, approximately, one mile away.

V. Bullet wound in head. Entered in mid-line at "nasion." Neat punctured hole, size to admit lead-pencil. No exit wound. Patient semi-comatose, later became quite unconscious, (5 p.m.) 7 p.m. Very bad.

Rapidly spreading sub-conjunctival ecchymosis to each ye. Died 9 p.m.

VI. Fracture of left femur from collapse of trench after heavy shell-fire (Black Maria). Treated in ordinary way or splint; bad position. A perfect case for plating —to await operation at Southampton.

VII. Bullet and shrapnel wounds of both hands, general shattering of metacarpals and phalanges. Nasty gaping wounds exposing everything down to the muscles themselves. Tendons exposed at the bottom of a sloughing mass of muscle and aponeurosis—apparently deep flexor tendons. Skin, edges curled inwards and bluish colour. No fragments felt on probing thoroughly. Morphia ½ gm. and 5 c.c. anti-tetanic serum.

ANAS BOSCHAS.

(To be continued.)

Letters from Guy's Men on Active Service.

No. 11 General Hospital,
Boulogne,
January 12th, 1915.

Dear Tanner,

Just a line for the GAZETTE. I am now here after various experiences with a Field Ambnlance, and the 2nd South Lancashire Regiment. We went through the battles of the Marne, Aisne, and Flanders, and saw many interesting and pathetic sights. At various times I have met Mr. Davies-Colley, Philip Smith, A. J. Eagleton, Pryn, Pern, Griffin, John, Bevan, Brown, John Watkin, Jamie Stewart, Frank Cook, Passey, Sherris, Reynell, the late H. L. Hopkins, Marshall, Starling, and many nurses. Here we are now chiefly medical, but have had plenty of surgical experience.

Our chief regret is that we are able to do so little for the poor Tommies. Several old Guy's nurses are here, including Sisters Campbell, Douglas, Phillips (of Corny), Mitchell, Southcott, Barker, Twose, and Daniel. Others have gone on to Clearing and Stationary Hospitals.

We had quite a decent Xmas, but wish we could have spent it in the Boro'. We are glad to see that so many Guy's people are now at the front, and hope that others will soon join us. With best wishes for the New Year from us all.—Yours, L. GWYN-DAVIES.

No. 3, Field Ambulance,
1st Division,
British Expeditionary Force,
January 13th, 1915.

You will see from the above address that I have at last got a move. Nothing exciting to relate as the field ambulance is resting, a few miles away from the firing line, in a small town.

Incidentally, it is more comfortable here than at ——. Billetted in a furnished chateau; several of us are sleeping out. I am sleeping along with Pern in a room over a shop. Pern has been with this field ambulance since the beginning of September, so he has had a pretty thick time, Yesterday, however, he was sent off as M.O. to a Territorial battalion out here. I left —— last Friday night, and I never want to see the —— spot again.

I have not seen much of the country round here, but it is very flat and flooded in parts. Talking of floods reminds me forcibly of something—Pern and I rode out the other day to a chateau that the field ambulance had been shelled out of, as he had left some things there; part of the road was flooded, and my horse got in a hole three or four feet deep at the side and came down. We both (horse and myself) got a top-hole ducking, nearly up to my neck. I did not get back to our billet for two hours, so Pern saw the most humorous side of the incident. However, I was none the worse for it. Well, old man, I hope you get out here soon, attached to something decent.—Yours ever, F. D. ANNESLEY,

Driver F. W. Crook,
Artists' Rifles Transport,
British Expeditionary Force.
January 3rd or thereabouts, 1915.

Very many thanks for your good Xmas wishes and also the New Year. We hardly realise they have come to pass. Well, how goes it with you? I hope not so rusty as you seem to think. I don't consider you have anything to grumble at, as we have stuck in this place for six weeks or more, and have not been doing anything. The only change was when the battalion recently went into the trenches for a week, and of course the Transport moved up with them. This was not very exciting for us except when supplies were taken up near the firing line to a farm, and the snipers were pretty prevalent. Another chap and I had a bit of excitement when half the battalion went digging reserve trenches—we drove the tool carts with entrenching appliances; it was a very fine day, and the Germans could see us, and so started shelling. I can tell you we had to shift pretty soon. One of the shells burst in a trench H. Company were digging, and killed four men and slightly wounded another.

I suppose you have seen that the Scottish have given a good account of themselves, also, the H. A. C. have been doing some good work. We have been made into an O. T. C., and they have already taken 400 of us. Monk went with the first batch, and I have just heard that the poor old chap has been killed. He was in front of his regiment, and died in the barbed wire of the German trenches. He was such a good sort, and I feel very cut-up about it But still, whatever he did he would have done well, I am sure of that.

Fatty Johnson has been wounded, but how or where I do not know. The transport men are necessarily given commissions slowly, but my name is down and I hope it will be soon, and so do all of us.

If I get the chance I will certainly give 'em a —— good one for you.

Well Chin Chin old chap! love to all the others. I hope to see you all out here soon. My love to old hospital pals.—Yours dripping. FRANK.

Somewhere in France,
January 17th, 1915.

Dear Stanley,

Many thanks for your letter, which cheered me up wonderfully. We have —— —— —— —— —— a —— time. Two days ago —— —— —— and —— —— —— —— —— there was —— ——. Afterwards we ran into —— —— —— —— —— —— and —— ——!! A few nights —— —— —— —— —— in —— —— morning —— —— ——. I often think —— —— —— and leave —— —— —— ——. You should have seen —— —— —— —— —— Good —— —— —— —— ——. Will write again soon and give you more news. —— —— —— —— —— What —— —— —— ——

Cheer oh!!

Yours ever,
"G. D."

P.S.— —— —— —— —— —— —— ?

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

DEAR SIR,—I should be grateful if some of your readers would give their opinion on the following point.

On performing laparotomy for acute abdominal conditions, how often does one find engorgement of the lactials showing that active digestion and absorption is going on? If found can the conclusion be drawn that no peritonitis or acute obstruction will be discovered and therefore that the operation has been unnecessary? The question was raised by the following case.

A man, aged 20, came off guard at 8 p.m. feeling quite well, at 9 p.m. he had an attack of acute abdominal pain which continued till operation. He was sick twice, vomiting partially digested food. Bowels had been open twelve hours previously but nothing had passed since.

Two years previously he had been operated upon twice for appendicitis.

C.O.A., P. 108., T. 98·, does not look very ill., tongue very slightly furred, abdomen generally tender and painful, and very rigid, no localization of symptoms or signs.

Operation was immediately performed, and the most striking fact was the injected lactials recalling an illustration out of "Cunningham," Careful search revealed a certain amount of kinking of the lower few inches of the ileum but no organic obstruction was found.

The wound was sewn up and patient made an eventless recovery, as no doubt would have happened on exhibiting an ounce of Oi. Ric.—Yours truly,

G. E. GENGE-ANDREWS.

Obstetrical Note from the "Observer," January 17th, 1915.

CARDINAL MERCIER'S CONFINEMENT.

GERMAN PRESSURE ON HIS EMINENCE.

I should like to ask, Mr. Editor, whether pressure is regarded as good treatment in this early stage, especially having regard to the present Teutonic habit of overdoing things. FRED. E. WALKER.

Pass List.

University of Cambridge.

THIRD EXAMINATION, DECEMBER, 1914.

Part I. Surgery and Midwifery.

D. V. Pickering, B.A.	C. M. Ryley.

Royal College of Surgeons.

CONJOINT EXAMINATION.—SECOND EXAMINATION.

Anatomy and Physiology.

J. A. Berry.	L. Gill.
F. Caldecott.	J. C. C. Howe.
O. St. L. Campion.	G. A. Pennant.

At the First Professional Examination of the Conjoint Board, held on January 5th, 6th, 7th and 8th, the following Candidates were approved in the subjects indicated:—

Chemistry and Physics.

C. Gill-Carey.	A. G. M. Severn.
J. E. van der Merwe.	

Biology.

J. B. Acuna.	A. A. Osman.
C. R. Cade.	J. van der Merwe.
C. Gill-Carey.	A. G. M. Severn.
C. Moffatt.	G. W. Wheldon.

At the quarterly Examination in Practical Pharmacy, held on January 14th, the following candidates were approved:—

H. G. Dresing.	G. D. Gripper.
L. Horsley.	H. Parry-Price.

BOOKS, ETC., RECEIVED.—The Middlesex Hospital Journal, The University College Hospital Magazine, The Nursing Times, The Hospital, The MS. Journal, The Universal Medical Record (from Dr. T. D. Lister), ournal of Clinical Research.

A Case of Perforation of a Typhoid Ulcer of the Jejeunum. Suture of the Perforation. Recovery.

BY PHILIP TURNER, M.S.

FRANCIS HENRY B., æt. 24, was admitted to the Hospital on March 11th, 1914, at 10.30 a.m., with the following history:—He felt well when he went to bed on March 10th, but at 4.30 a.m. on the 11th, woke up with a very sharp and violent pain in the epigastric region. He had several violent shivering fits but there was no vomiting. Hot flannels were applied and afforded some relief, but the pain continued. He was seen by a doctor the next morning who advised immediate removal to the hospital. The patient was so ill when first seen that it was with difficulty that this brief account of his illness could be obtained. The following additional details were given by his mother and were subsequently confirmed by the patient himself. Three weeks before admission he had an attack of "influenza," this commenced with a shivering attack, and he also had "cold sweats" and severe headache and pain in the back. His bowels were constipated. He was in bed for four days and had three days at home before starting work. He had been back at work nine days when the present attack began, but during this time did not feel "up to the mark." Until the attack of "influenza" his bowels had always acted quite regularly, and his appetite and digestion had been good. There was no history of any injury, and he had never had typhoid fever.

On admission he was restless, groaning, and obviously very ill and in great pain. The pulse rate was 108, the temperature 97, and the respiration rate 36. The abdomen was slightly distended and was uniformly tender; the upper part was extremely rigid, but this was less marked in the lower part, which showed slight respiratory movements. The tongue was dry, and covered with a thick yellow fur.

From the history of the illness, and from the condition found, there was no doubt that the patient was suffering from general peritonitis, in all probability secondary to some perforative lesion of the gastro-intestinal tract. The very rapid onset, the severity of the pain, and the fact that the tenderness and rigidity were especially marked in the epigastric region, led one to make a diagnosis of perforated gastric or duodenal ulcer, especially with the imperfect history which was then available.

The patient was at once taken to the theatre and ether administered by the open method. The abdomen was opened by a median incision above the umbilicus. Immediately on opening the peritoneum some gas escaped, and this was followed by a rush of fluid of which there was a very large quantity. It was at once noticed that this fluid differed in several respects from the fluid usually found in cases of perforated gastric ulcer. It had a distinct fæcal odour instead of the sour odour usually found after the leakage of gastric contents. It was also brown and turbid, and contained many large masses of greenish coloured lymph. The stomach and duodenum were drawn into the wound, and were found to be normal and without any evidence of a perforation. The incision was then lengthened in a downward direction, and the cæcum and the appendix were examined, but showed nothing to account for the condition found. The coils of small intestine were then gently separated and inspected, when the perforation was soon found in a coil of small intestine situated just to the right of the umbilicus. The opening was about the size of a sixpence, and presented several interesting features. It was not like a tear such as one sees after a traumatic laceration, neither did it at all resemble the small opening with surrounding induration such as is found with a perforation of a gastric or duodenal ulcer. Its appearance rather suggested that a slough of the whole thickness of the intestinal wall had separated. Thus without in any way holding the edges apart, it was possible to see the intestinal mucous membrane, and to observe that small valvulæ conniventes were present. The opening was not quite circular and the margins were not jagged, but seemed to show evidence of granulation. As regards the position of the perforation, it was, of course, impossible to pull out the intestine and ascertain its distance from the ileo-cæcal valve, but I am sure that it was a good way above this, and equally certain that it was a good distance below the commencement of the jejeunum. The fact that small valvulæ conniventes could be seen through the opening, makes it probable that the lesion was situated towards the lower end of the jejeunum.

The margins of the opening were first brought together by a continuous catgut suture passing through all coats to a line at right angles to the longitudinal axis of the intestine, which was also the long axis of the perforation. While

passing these sutures the tissues were so friable that the stitches cut through on two or three occasions. This first suture was then buried by a continuous Lembert's suture of fine catgut. A conveniently situated piece of omentum was then sutured to the bowel so as to afford additional protection. It was then found that the pelvis contained an enormous collection of fluid similar to that which escaped from the abdomen. A stab-cut was made just above the symphysis, and a large tube was introduced deeply into the pelvic cavity. Two rubber drainage tubes, one passing to each loin, and a gauze drain passing directly backwards were now inserted through the original incision which was afterwards closed as far as possible by a double layer of catgut sutures for the abdominal wall, and a few silkworm-gut stitches for the skin. The fluid was removed as far as possible by compressing the abdominal wall; no attempt was made to cleanse the peritoneal cavity by swabbing or by irrigation. As soon as the patient was back in bed he was infused, and when he had come round from the anæsthetic he was placed in Fowler's position. The usual precautions in nursing a typhoid case were taken at once.

Next morning his condition was quite satisfactory though the pulse-rate was still 120. There had been but little post-anæsthetic vomiting, and a large quantity of fluid had drained away through the tubes. A specimen of blood for a Widal's reaction was taken and the result was strongly positive. This was repeated several times while he was in hospital and always with the same result. Dr. Eyre and Dr. Lucey had no doubt that the patient was suffering from typhoid fever. The urine also gave a positive diazo reaction.

There was nothing much to say about his subsequent progress. The tubes were all removed on the third day and were replaced by smaller and rather shorter rubber drains. The abdomen remained distended and tender for some days but this gradually disappeared. The bowels had not acted by March 17th, but on that day there was a satisfactory evacuation after an enema. The enema was afterwards repeated on alternate days with excellent results. For four weeks after the operation there was marked pyrexia, the temperature reaching about 101·4 deg. in the evening, sinking to normal in the morning. For another two weeks or so the evening temperature showed a slight rise to about 99·4 deg. after which the temperature became normal. The wounds made slow but steady progress: there was superficial suppuration in the upper wound which gaped widely and healed by granulation. While the temperature was up he was kept on a light fluid diet, milk, tea, broth, soup, Benger's food, and ovaltine being chiefly used. On March 30th, there was odema of the left ankle which spread up to the leg and thigh: there was no pain but he was kept on a back splint and the swelling gradually disappeared. There was also a mild attack of bronchitis. Several bacteriological examinations of the fæces and the urine were made but no typhoid bacilli could be identified. An examination of the pus from the wound showed the presence of B. Coli and a streptococcus.

The diagnosis of this case was a matter of considerable difficulty. Although no typhoid bacilli were ever identified I think that there is no doubt that this was a case of typhoid fever, though in many ways it was atypical. Typhoid perforations of the jejeunum are much less common than perforations of the ileum, but if this was the jejeunum it was at the lowest part of that portion of the intestine. An alternative suggestion I heard made was that the perforation might have been secondary to an embolism of one of the small branches of the superior mesenteric artery. It is difficult, however, to see how such a lesion could give rise to such a small localised perforation of the intestine; besides which there was the well-marked positive Widal reaction obtained on every occasion it was tried. The history of the preceding attack of "influenza," requiring three days in bed and four days rest, is also in favour of this being a case of ambulatory typhoid fever. The prolonged duration of pyrexia after the operation is also of interest, as it continued long after the abdominal suppuration had ceased: there was never any evidence of a sub-phrenic or other residual abscess. The diagnosis before the operation was perforation of a gastric ulcer, and I do not think that with the imperfect history then attainable that a more accurate diagnosis could have been made.

I had previously operated on three cases of perforated typhoid ulcer, all of which died (see a Clinical Lecture on Three Cases of Perforated Typhoid Ulcer, *Guy's Hospital Gazette*, October 11th, 1913). One of these was a case of ambulatory typhoid in which a diagnosis of perforated gastric ulcer was made, death occurring shortly after an exploratory operation. The true nature of this case was only revealed at a post-mortem examination. The following is a brief account of this case, which it is of interest to compare with the above.

Edward James C., æt. 46, was admitted into Clinical on December 8th, 1912, under Dr. Hertz for acute abdominal pain. His condition was very grave, indeed he was so ill that it was with the greatest difficulty that any account of his illness could be obtained. The patient told us that for two weeks before admission he had suffered with abdominal pain, chiefly in the epigastric region. There had been no vomiting and his bowels had acted regularly; for a considerable part of this time he had been unable to work and had rested in bed, but had not seen a doctor. Three days before admission the pain had become much worse, and he had vomited several times during the preceding night. Before the present trouble he had for some time suffered from indigestion.

On admission the pulse rate was 120. The abdomen was distended and did not move on respiration. Above the umbilicus it was rigid and tender. On percussion there was no liver dullness. The patient obviously had general suppurative peritonitis, and, taking into account the previous history of indigestion, and the situation of the pain, tenderness, and rigidity, the probable cause of this appeared to be a perforated gastric or duodenal ulcer which had first of all leaked giving rise to a local collection of pus which had subsequently extended to the general peritoneal cavity. A laparotomy was performed without delay. The peritoneal cavity was opened by a median incision above the umbilicus. Pus and gas escaped at once and it was found that there were numerous recent adhesions matting together the intestinal coils. An investigation of the stomach and duodenum showed no evidence of perforation or ulceration. A second incision was then made in the right semilunar line below the umbilicus to expose the appendix, but though the same condition of suppurative peritonitis was found, this structure showed no pathological change to account for the condition of the peritoneum. The condition of the patient was now so grave that no further search for the cause of the trouble was possible. The peritoneal cavity was accordingly drained and the patient sent back to bed. He died a few hours later.

At the post-mortem examination numerous typhoid ulcers were found chiefly in the ileum; one of these had perforated and was the cause of the peritonitis. Many of the ulcers were healing, and hence one had to assume that the perforation had occurred during a relapse. This case was undiagnosed: no one had thought of the possibility of the case being one of perforated typhoid ulcer, either before or during the operation. My own opinion at the time was that there must have been a perforation of a duodenal ulcer, which, owing to the presence of the pus and the intestinal adhesions, I had been unable to find.

There is a considerable resemblance between these two cases. Both were admitted from the Front Surgery as acute abdominal cases, and in both a diagnosis of perforated gastric or duodenal ulcer was made. Both were cases of ambulatory typhoid, and in neither case was there anything in the history to lead one to suppose that the patient was suffering from typhoid fever. Probably the acuteness and urgency of the perforation, and the imperfect history obtainable in each case, helped to prevent recognition of the true nature of the trouble. One lesson to learn from these two cases is that perforation of an ulcer in a case of ambulatory typhoid must be thought of in addition to many other lesions in obscure acute abdominal cases. The first case is also of interest because it is, as far as I have been able to ascertain, the first case of perforated typhoid ulcer to recover in this hospital.

PHILIP TURNER.

Vignettes from France.

IV.

WE had left the Marne behind us, and were pressing forward over the flat-topped hills which line between that river and the Aisne. As usual, we had breakfasted early, and at seven o'clock had already been on our way for three hours. We arrived at the top of a hill in the rain, and although our out-look to the front and our left was shut off by high banks, on our right we could see for some miles.

We came to a halt well on the sky-line. Shortly after we had come to a rest, a battery of French 75.'s opened fire about two miles away on our right. We could see their shells dropping with marvellous accuracy on the crest of a hill opposite them, covering the ridge with white smoke. After about half an hour the batteries suddenly stopped, and we could see through our glasses little black dots climbing up the side of the hill, reaching the top without opposition.

This entertainment concluded, it was necessary to find some other form of amusement, and strolling forward we came across two German cavalrymen who had been captured by us earlier in the morning. These were surrounded by a crowd of Tommies who were busily engaged in testing the gastric capacity of these happy-looking Huns. Bully, biscuits, jam and bread were eaten as fast as offered, and I was assured that they had already been eating solidly for the better part of an hour.

Shortly after this we moved forward down the hill, while they attached themselves to the brake of an ammunition wagon, a military policeman being in close attendance. They were quite happy and worked the brake when necessary, eating green apples with which their pockets were well filled. On reaching the bottom of the hill we halted on a bridge over the river which the Germans had omitted to destroy. The river there is a swiftly running stream about forty feet wide, but not very deep. The Germans had been obliged to leave behind them some ammunition wagons filled with "77" shells, and these, when the English arrived, had been thrown into the river to the number of about 400, and formed a pile reaching right across the river, in some places projecting above the surface of the water.

Guy's Hospital Physiological Society.

THE weekly mseting of the Society was held on Monday, 18th, when Mr. Caldecott read a paper on "Darwinism in the Nursery," before a record meeting. The reader of the paper unfortunately confined himself to the movements of infants, deducing from these the descent of man from an aquatic ancestor through one of arboreal habits. He carefully pointed out how the involuntary movements carried out by infants would aid them in progression through an aquatic medium. The movements of the embryo in utero were also mentioned, but several members showed the difficulty of observing such movements, and this part of the paper consequently carried little conviction with the meeting. The reader of the paper devoted much time to the description of the use of the thumb by infants of varying ages, and by comparing these movements with those of the same digit in animals of arboreal habits, deduced strong evidence for his contention of man's descent through an arboreal ancestor.

The discussion which followed the paper was of a more general nature, the arguments advanced ranging on the serious side, from the morphology of the gill clefts, to the advantages and disadvantages of a moustache on the lighter side. There can be little doubt that the latter argument was suggested by the excellent growth of one of the members while away on military service.

Many members expressed the opinion that speech was one of the surest signs of our superiority to the apes. A new member, however, pointed out that excess of speech did not necessarily imply excess of intellect—the Chairman acknowledged the truth of this remark, and then turned the attention of the members to the similarity of sounds emitted by infants, cats and lions.

The Secretary then endeavoured to explain the origin of the belief that woman was developed from the rib of man, but adding bad arithmetic to bad anatomy, he took Mr. Maxwell's hint and sat down.

Mr. Grey told the meeting that he had 14 nephews and nieces, but beyond that, he carefully avoided the subject under discussion on every occasion he rose to speak. One was struck with the little information the chair had to offer on his acquaintance with the young. The meeting closed at 6.30 with a hearty vote of thanks to Dr. Pembrey for occupying the chair, aud to Mr. Caldecott for his paper.

Appointments.

Civil.

M. G. Dundas, M.R.C.S., District Medical Officer of the Pembroke Union.

R. Kay, M.B., District Medical Officer of the Bideford Union.

Naval.

To be temporary Surgeon: F. R. Featherstone to the *Pembroke*.

F. W. Paul to be Dental Surgeon to H.M. Hospital Ship *Garth Castle*.

C. Glover to be Dental Surgeon to H.M. Hospital Ship *Plassy*.

Royal Army Medical Corps.

To be temporary Captain: E. A. Peters.

To be temporary Lieutenants: D. W. Jones, G. R. Phillips, A. S. Taylor, G. E. Genge-Andrews, H. C. Godding, A. G. Plumley, E. G. Myott, H. H. Carter.

2nd Eastern General Hospital.—The undermentioned Captain to be Major (temporary), W. H. Brailey.

2nd London Sanitary Company.—To be Lieutenant. G. L. Eastes.

2nd London Casualty Clearing Station.—To be Captain, G. H. Hunt,

3rd Southern General Hospital.—J. F. Robinson to be Captain, whose services will be available on mobilisation.

1st East Lancashire Field Ambulance.—Lieut. Stanley Hodgson, from attached to other than medical units, to be Lieutenant.

Territorial Force Reserve, R.A.M.C.

Captain E. P. Minett, from 6th London Field Ambulance, to be Captain.

Other Units.

T. A, Townsend has joined the British Red Cross, and will proceed to Serbia shortly.

Guy's Hospital Dental Society.

Address on Fractures of the Jaw

Delivered at the Hospital on Tuesday, Dec. 1st. 1914, by J. LEWIN PAYNE.

Mr. PRESIDENT,—When you, sir, a week or two ago, asked me to come here and speak on this subject, I readily consented; but, upon further reflection, I began to wonder whether I had not been rather rash in promising so suddenly to present a subject upon which I cannot hope to give you anything new, or, indeed, anything beyond what you can find already in the text-books of our profession.

Nevertheless, I am glad to be present at this meeting of the Guy's Dental Society, for I feel profoundly that this society represents a very important branch of the work of the Dental School, and that, after all, this is an opportune time for re-stating the treatment of fracture of the jaw. Are we not in the midst of a war the extent and devastation of which probably exceed anything that has been previously experienced in the history of the world? And in connection with this war, have we not been forced to the conclusion that such jaw injuries are to-day inevitably and exceedingly common? Again, in this hospital we have ample opportunities of seeing troubles in connection with fracture of the jaw, for, for good or evil, we are located in the neighbourhood of the Borough, where quarrels occur frequently between men and men and men and women that lead to this injury under discussion. Further, the whole subject is peculiarly interesting to the dental surgeon, because it serves to supply the widest scope to that combination of mechanical skill and surgical knowledge which forms the ideal of modern dentistry.

Before coming, however, to the actual treatment of fracture of the jaw I ought, perhaps, to outline briefly the causes, type, signs, and symptoms of this injury. First, as to ætiology. This fracture is almost always due to direct violence: for instance, a kick, a blow, a fall. It may occur in the dentist's hands during extraction; and this mischance was formerly much more common than it is to-day, when the key was an instrument in frequent use for the purpose of extraction. There is also that group of cases in which we are specially interested at the present time, namely, the results of gunshot wounds. In ordinary times of peace, gunshot wounds of the jaw are comparatively rare; but since the war started, I have had the opportunity of seeing several of these cases already.

The prevalent type of this fracture is almost always compound; and it so owing to the position in which it occurs. It is certainly compound in about 90 per cent. of the cases when fracture occurs either in the maxilla or in the body of the mandible. There it is in relation with the fibrous tissue of the gum, which is inelastic and will tear readily, and consequently the fracture almost invariably involves the free surface.

The most common sites are the canine region, usually just behind the root of the tooth. Next in frequency comes the region of the mental foramen in relation to the premolar teeth. Then comes the symphysis. It was thought that fracture of the symphysis occurred very rarely, but there are records of many cases in which the lesion was found there, and I have also seen several myself. Another common site is the region of the third molar, either in front or behind, or in a line with, the apex of its root. More rare fractures are those occurring in the ascending ramus, in the condyle, and in the coronoid process of the jaw. These last three forms may be simple fractures, because, being deeply seated, the surface is not necessarily exposed. Let me add a word about gunshot fractures. They are nearly always comminuted, though now and again the fracture may be single. In most gunshot cases, however, the bone is splintered up, and naturally this increases the difficulty in treatment. The wound is clean at first, but, because of its relation to the mouth it will readily become septic. And so periodontitis in connection with a tooth may set in, then in neglected cases an abscess forms, followed by a sinus, and some necrosis of bone.

Fracture of the upper jaw is often associated with more serious injuries and may be complicated with fractures of other bones of the face or even of the base of the skull. These fractures may be due to the same causes as those which give rise to fracture of the lower jaw, but they are usually associated with very severe violence, such as a fall from a height, an explosion, or gunshot wound.

Now let us deal with signs and symptoms. The first feature to be noticed upon examination is an alteration in the line of the teeth, though I have seen several cases of fracture, even of the horizontal ramus, where there was no displacement. Probably there will be undue mo-

bility, pain, and crepitus. In some cases crepitus may be the only definite sign. Last week I saw a case in which there is a fracture of the coronoid process. The only two symptoms which indicate this sufficiently are pain in the region, and the crepitus which can be felt. As secondary symptoms, one gets an increased flow of saliva; and later there may be foulness of the breath and swelling.

There is also one other important sign not mentioned, I believe, in the text-books; it is a sign which was pointed out by Mr. Frank Coleman two or three years ago. Whenever fracture of the horizontal ramus of the mandible occurs, an effusion of blood takes place in the tissues between the tongue and the mandible, giving rise to a tense bluish swelling. Since this sign was described I have noted it in all cases of fracture of the horizontal ramus of the mandible, and it may be regarded as a most useful means of diagnosis.

In these days the X-rays will be employed in almost every instance as an additional aid in the diagnosis, and as a guide to the best method of treatment.

With regard to deformity, displacement is produced by the action of the muscles and the obliquity of the fracture. Thus, the anterior fragment, *i.e.*, the larger fragment of the two, if there are only two, is usually drawn downwards and somewhat backwards. The lesser fragment is drawn upwards by the muscles which close the jaw. Of course, the fracture may be a multiple one, and the condition is so much the more complex. The central fragment will then be depressed by the genio-hyoid, genio-hyo-glossus and digastric muscles and at the same time it will be pulled towards the tongue.

I must now pass to the subject of treatment, because it is that to which I want to refer specially this evening. In this there are two important factors to consider. The first is the cleanliness of the mouth; the second is the relationship of the fragments. Of the two, I should be inclined to affirm that the first is the more important, because one finds that, taking fractures of the jaw as a whole, they do extraordinarily well, even when the treatment has not been as accurate as we could wish. A very great deal does depend upon the manner in which mouth hygiene is attended to during the process of treatment. Very loose teeth in the neighbourhood are better out of the mouth. They must be carefully removed so as not to cause any injury beyond that which is absolutely necessary to extraction. They should be taken out because of the risk of sepsis, and the interference with union. Roots should also be extracted for the same reason. Teeth which are carious, or have any other dental disease, should be treated where this is possible, and tartar must be removed before other surgical treatment is undertaken. The regular use of mouth washes should be adopted, not so much because of their antiseptic value as for the mechanical cleansing which their use insures. One also finds it helpful to employ a tongue-scraper in cases where interdental splints prevent the use of a tooth-brush on the lingual side of the teeth. I strongly advise the use of some mouth spray, with which one can force fluid between teeth and in regions which cannot be reached with the tooth brush. During treatment the food must be, for the most part, in the form of slops; obviously when certain splints are in position it is impossible for the patient to masticate, and in any case mastication is forbidden during the early days of the treatment.

Patients who can be placed in a hospital bed, or in a nursing home, will do much better if they can have either nasal or rectal feeding rather than food viâ the mouth, because food, lodging at points in contact with the teeth and the wound, often leads to fermentation and sepsis. Rectal or nasal feeding may seem drastic, but in the end I believe it saves trouble.

The patient should laugh as little as possible during the treatment, and yawning specially should be avoided. In sleep it is better for the head to rest on the occiput, rather than on the side, so that there may be no tendency to displacement.

Now let us take operations and appliances. In the past, I think, we aimed at a wrong ideal, for we aimed at absolute fixation. In the treatment of fractures at the present day, it is generally recognised that it is rest, not fixation, that is really required. As a matter of fact, it is almost impossible to *fix* the mandible in position. In the process of deglutition, even when taking soft food, there is some movement of the jaw; that small amount of movement is inevitable, but it will not matter. Probably few bones unite better than do the ribs, and yet one cannot prevent movement of the ribs after fracture. Moreover, we as dental surgeons treating these cases, should interfere by introducing some passive, and even active movements at certain definite times. Thus massage should be commenced quite soon, and passive movements in two or three weeks. There is no reason why some active movements of the

mandible should not be allowed even before firm union has taken place.

The surgical wiring of fragments I believe to be of great value in those cases in which fracture has occurred in the ascending ramus, and specially when it is desired to re-unite a broken coronoid process or a broken condyle with the mandible. But when the wiring is applied to the horizontal ramus of the jaw, this treatment often fails. I believe the reasons are these. In the first place, it is almost impossible to keep the mandible and the mouth in an aseptic condition, and so you cannot maintain a perfectly clean wound. Secondly, the wire which is introduced will frequently work loose, because of the amount of mobility which occurs in the mandible during deglutition. Thirdly, the space between the teeth where it is sought to pass the wire is not sufficient to prevent the periodontal membrane from becoming infected. Therefore, with the horizontal ramus I think it is better to adopt some method other than wiring.

We now pass to the use of bandages and splints, and I shall demonstrate these by means of the epidiascope.

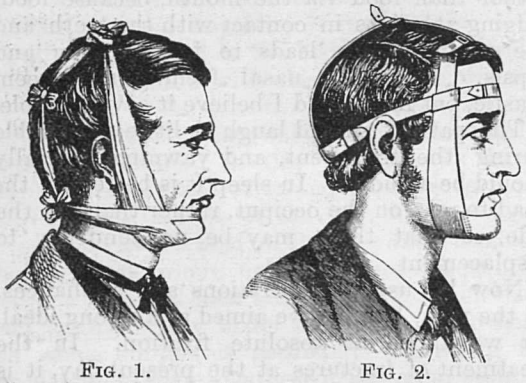


FIG. 1. FIG. 2.

From Heath's "Injuries and Diseases of the Jaw."

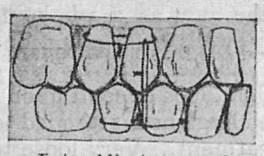
As an external application the well known 4-tail bandage (Fig. 1) has been the most widely used, and it was formerly employed in conjunction with an external gutta percha or a plaster of Paris splint. Though this bandage may serve as a temporary support it does not overcome the displacement of the fragments, and in the case of oblique fractures it tends to make the fragments overlap and thus to increase the displacement.

A much more efficient bandage is the Hamilton sling (Fig. 2) which was devised by Dr. Hamilton of New York, many years ago. As made at Guy's Hospital it consists of three pieces of stiff linen webbing about $1\frac{1}{4}$ inches in width. The first piece, called the maxillary, passes upwards from beneath the chin to a point near the situation of the anterior fontanelle. It passes through loops in the occipito-frontal portion made to prevent it from slipping, and its ends are caught by buckles attached to a Y-shaped piece of webbing on the top of the head. The occipito-frontal piece passes from the occiput to the middle of the forehead, and is placed just above the ears and secured by a buckle at the side. A vertical strap passes up from the occiput to meet the third buckle on the Y-shaped piece on top.

Tapes are often attached to the chin portion and tied round the neck to prevent the webbing from slipping forwards. A pad should be placed beneath the chin and at each point where a buckle is used. The advantage of this sling consists in its capacity to lift the anterior fragment of the fractured mandible almost vertically, and it will also retain its position on the head if properly fitted to it.

Additional support for the injured jaw may be obtained by using an external gutta-percha, plaster of Paris, or metal perforated splint in association with the Hamilton sling. The parts are thus protected, the jaw is kept at rest, and if there be no displacement of the fragments such treatment may suffice. In the majority of fractures of the horizontal ramus it is necessary, however, to secure the fragments by means of some appliance within the mouth in order to prevent deformity.

The simplest form of inter-dental splint is one made by the use of ligature wire. Wiring the teeth together was a method adopted in the early days of surgery. Hippocrates is said to have treated fractures by this method. Dr. Pickerill (of New Zealand) has suggested the employment of ligatures secured around the necks of two or more adjoining teeth in corresponding positions of the mandible and the maxilla. These two loops are then drawn together, so as to keep the teeth in normal occlusion, by a third ligature passing between the loops (Fig. 3).



Lateral ligatures on the premolar teeth.

FIG. 3.

Angle's fracture bands have been used in a somewhat similar manner. After fitting and fixing the bands firmly to the teeth with osteo, figure-of-8 ligatures are passed between the studs attached to the buccal side. Personally I have used such bands with success in several cases of multiple fracture.

For the construction of most interdental splints models of the jaws are necessary. These models should be carefully articulated. This is done by cutting the model, showing the displacement at the line of fracture, and re-arranging the sections so as to bring the teeth into correct occlusion. The pieces are then united in the new position, and are mounted upon an anatomical articulator.

The Tomes splint, or Mütter's clamp consists of a metal trough which fits loosely over the teeth, and when the fracture has been set the trough is filled with soft osteo or gutta-percha and is held in position until quite firm.

The Hayward or Kingsley splint is a metal or vulcanite cap, covering the lower teeth, to the front of which stout wires are so attached that the wires may pass outside the cheek when the splint is in position. These wires serve to hold a stiff bandage which passes under the chin and keeps the splint in its position.

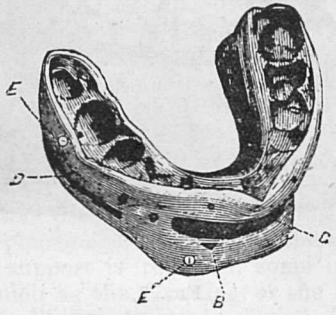


FIG. 4.
From Heath's "Injuries and Diseases of the Jaw."

Gunning's splint (Fig. 4) is composed of vulcanite throughout. It is constructed to fit both the maxillary and the mandibular teeth—the two portions being joined together by vulcanite supports.

It is frequently held in its position against the teeth by the use of osteo or gutta-percha.

Hern's modification of this splint does away with the large palatal piece, and substitutes raised pillars of vulcanite hollowed out to fit the masticatory surfaces of the maxillary teeth. This is less cumbersome to the patient and is more easily kept clean than the ordinary Gunning splint.

The Kingsley modification of the Gunning splint consists in the addition of some holes (Fig. 4 *E*) made in the vulcanite to take small screws, which are allowed to pass between the teeth for the purpose of securing the splint more firmly in position.

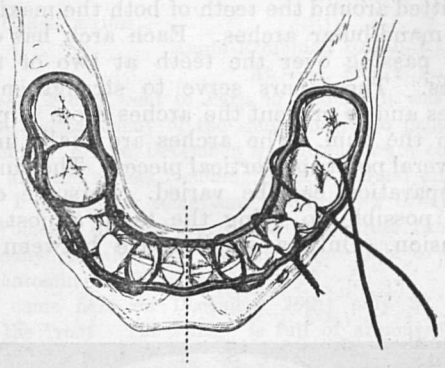


FIG. 5.
From Heath's "Injuries and Diseases of the Jaw."

The Hammond splint (Fig. 5) is made of soft iron or German silver wire, which is fitted closely round the lingual and labial surfaces of the teeth, the ends being joined together with solder. When the splint is ready the displacement of the jaw is corrected and the splint is fixed to the teeth by means of ligatures. The ligatures consist of fine iron or brass wire passed in a figure of 8 fashion over the top of the outer bar between the teeth and below the inner bar, returning over the inner bar and below the outer one as shown in the illustration. A sufficient number of these ligatures must be applied to hold the fragments firmly in position.

The ends of the ligatures having been twisted until tight, are cut short, and then tucked underneath the bar. The teeth immediately adjacent to the fracture should not be ligatured.

This splint has a very wide range of usefulness. It is easily made and is less inconvenient to the patient than most of the other forms. It is clean in itself and the parts can be easily kept clean when it is in position. However, it necessitates the presence of a number of firm teeth in the broken jaw, and is of little or no value when the fracture occurs behind the first molar. In those cases where there is a molar behind the point of fracture, Mr. H. Lloyd Williams has suggested the use of a vulcanite cap extension to fit over the tooth. Personally, in such cases I have not found this method sufficiently secure.

Another splint is the "Cradle splint" (Fig. 6). It is a kind of double Hammond. In its construction silver wire has been recommended in

preference to soft iron or German silver wire, because silver wire is more adaptable, and if gilded, does not perceptibly change colour after insertion in the mouth. When the models have been carefully articulated and mounted upon an anatomical articulator, the wire frames are fitted around the teeth of both the maxillary and mandibular arches. Each arch has cross bars passing over the teeth at two or three places. These bars serve to strengthen the arches and to prevent the arches from slipping on to the gum. The arches are finally united at several points by vertical pieces. The amount of separation can be varied. In some cases it is possible to bring the teeth almost into occlusion. Only a small space between the teeth is really required for feeding. As I have pointed out already, for the right use of the Hammond splint there must be a number of firmly implanted teeth, and the fracture must be towards the front of the mouth. For any fracture behind the first molar, a simple Hammond is not suitable. The cradle splint will often serve in such cases and also in those where the teeth are not quite firm, and in which further support is required than a Hammond can give. A cradle splint in comparison with the Gunning has this advantage, you can see what is going on all the time, whereas when the Gunning has been fixed you do not always detect displacement until too late. The cradle splint is easy to clean, and this is such an essential part of the treatment of fracture of the jaw. Fig. 6 shows the splint in position on the model. Usually it is only necessary to wire it to the mandible, and it is better not to put ligatures at the maxilla as well, because the passive movements I have spoken of would thereby be hampered.

Fig. 7 shows an adaptation of the same splint when one jaw is edentulous, while the other has teeth standing. You can apply a vulcanite covering over the edentulous portion, and attach the wire cradle to the upper or lower arch, as the case may be.

With regard to the length of time that these splints are usually worn, it should be noted the period is from four to six weeks, and although non-union in fracture of the jaw is comparatively rare, it does occasionally happen that you have to wait ten or twelve weeks before union takes place, and that is common only in instances where there has been extensive suppuration. The difficult cases usually arise from sepsis. Hence cleanliness is our sheet anchor. If we are not very careful ourselves, and insist that our patients be careful too, there are considerable risks that union will be delayed.

Of those I have shown you, I think the Hammond stands first for the great majority of cases calling for a splint. That is so because of its simplicity, its cleanliness, and its adaptability. When the fracture is either behind the first molar, or the teeth are loose and you

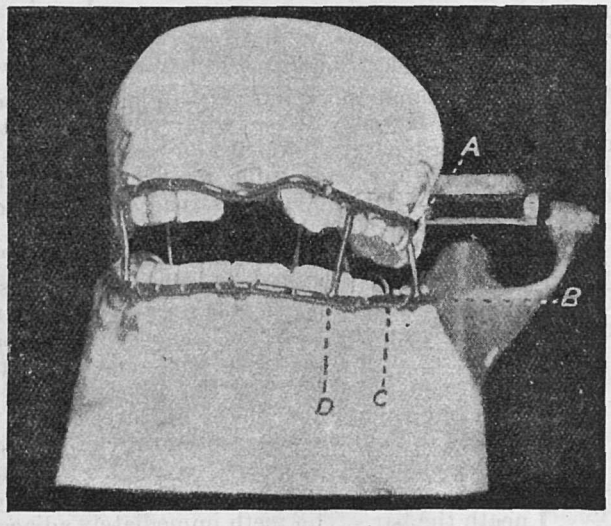


FIG. 6.

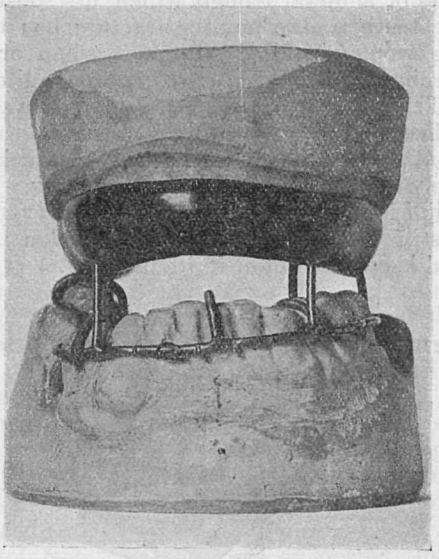


FIG. 7.

cannot get sufficient support with the Hammond, you may use a cradle splint. In cases where there are few teeth, or none, you must use the Gunning. Nowadays most people who have no natural teeth have artificial substitutes, and all you will require to do is to articulate and unite the dentures with vulcanite, and you have your Gunning splint practically ready.

With regard to the time at which the splint should be applied, that will depend on the condition. Usually it should be applied within the first twenty-four hours; but if there be much effusion and swelling in the neighbourhood, it is better merely to adopt some simple appliance to afford rest, such as the Hamilton sling, and wait until most of the effusion has disappeared.

In fractures of the maxilla, as opposed to fracture of the mandible, it should be further observed, we have very much greater vascularity and more opportunity of drainage, so that union will occur more readily in the maxilla than in the mandible. There are few cases which will not unite, unless the damage has extended far beyond the maxilla itself. And whereas in the case of a mandible you may have to remove several teeth, in the maxilla you should retain every tooth possible, because the fragments, even though only slightly adherent, will tend to become firm in the latter case. The practical difficulty in the maxilla is hæmorrhage. There is sometimes troublesome and extensive hæmorrhage, which may require careful treatment.

In correcting maxillary displacements, it may be desirable to place your thumbs deep in the sulcus and press on the zygomatic arch, and after replacement to ligature the teeth. If further support is required, some inter-dental splint, such as the Gunning, or the Hammond, or the cradle may be used.

For the immediate treatment of fractures of this type which may occur at the seat of war you should keep one or two Hamilton slings available. These can be easily copied if you have sufficient webbing. Lint, wool, lotion, some stout ligature wire, and pairs of tweezers, pliers, and shears will also be required.

In conclusion, I would urge that this particular branch of surgery is one in which the dentist should be called in to co-operate with the surgeon. The most important types of apparatus in use in the treatment of fracture of the jaw have been invented by dentists, and their familiarity with these parts and their knowledge of mechanics specially fit them to undertake this type of case.

Nursing News from Letters received at the Hospital or the Institution.

Miss Cadell writes:—

Anglo-Ethiopian Hospital,
At ——, Pas de Calais.

"When I first went to Paris in October it was very empty, a great many of the shops shut, and people in mourning. Before December the people were coming back, and the streets resuming a more normal appearance. I worked for some time at Claridge's Hotel with the Women's Hospital Corps. At Christmas time we had many convalescents, and they were able to enjoy the pantomime and concert.

"I came here on December 26th; only 20 miles from the front. The village is full of armoured cars and motor buses; 90 go up to the front every day with food. This building was a hospice belonging to nuns. Part had been used by the French military before we took it over. At present we have French and Algerian patients, a few wounded, but most are accident cases among the troops stationed here.

"The sanitary arrangements are the worst part of the hospital; otherwise, we are well equipped for a place so near the fighting line. The nurses have to sleep eight in a room, but we don't grumble."

From Miss A. E. Prince:—

"We are now at a little fishing village; a beautiful little spot, very quiet. It does just boast of a few shops, among which is a really good patisserie which is much patronised, especially by the medical officers.

"Here our hospital consists of two hotels, a casino, and a large villa for officers. There is accommodation for 800 patients, with very comfortable beds. Miss Mann and I are working at the casino, which makes a very quaint ward. Two tiers run round the room just wide enough to take a bed, so to go from one side of a bed to the other you have to jump down to the tier below and then mount up again, and as it is a good two feet, you have to be fairly active. The casino holds 84 beds, 12 being on the stage.

"Whe we first came there was no heating apparatus, and it was bitterly cold. Now we have two stoves and a third is to be put on the stage. The patients will be very pleased, as that was a very cold spot. They used to say they did not like being 'stars.'

"Our first convoy here consisted of 100 patients, the next 300, then 500, and yesterday 150. As soon as the hospital boat arrives the patients are sent off to England, and, of course, they are delighted to go. We are sorry to lose them just when we have got them clean and their wounds are beginning to improve with treatment.

"On Christmas Eve we were very busy, as two days before the convoy of 500 had arrived and there were some very bad cases. We had a death on Christmas Eve and one on Boxing Day. It is just marvellous how splendidly the soldiers bear pain.

"On New Year's Eve we did hope to give the patients a concert, but we were far too busy. It took place at last on Monday the 4th. There was a very good sketch called 'A Sister to a Sister,' given by two of the medical officers. Also a troupe of five sisters, Miss Sharwood and I among them, and nine M.O.'s. We were dressed as Puritans and the men as Pierrots. The topical songs were a great success, and the patients thoroughly enjoyed the concert.

"Our medical officer at the casino, Mr. Walker, has a brother at Guy's. Mr. Griffith was with us, but stayed on at ——, and I believe is now with No. 9."

Miss Mary Masters writes:—

Australian Voluntary Hospital,
Exped. Force.

"Ever so many thanks to all friends at Guy's for the letter, card, and handkerchiefs I received on Christmas Eve. I was called up by the British Red Cross Society on September 29th to go to France, and 33 of us left for Paris. I and five others were sent on by motor—a most interesting run of 40 miles on the north road—to a chateau situated in most delightful grounds. Here we spent six luxurious weeks, Baron de Rothschild having provided everything we could want.

"When first there we used to hear the guns all day, then more and more faintly, and then we ceased to get any more English wounded. We were then disbanded, as the French wounded were to be looked after by French Red Cross. Our cases at the chateau did well in spite of the 'Tetanus.'

"After waiting three days at Boulogne I was sent to the Australian Hospital. It was an hotel in the most beautiful position possible, on the very edge of the sea. When we first arrived crowds of badly-wounded men were arriving; nothing arranged; the place full of stuffy furniture. It was strenuous work, but everything was, in time, put in first-class order, and the whole place looks like a first-class hospital.

"I have met many Guy's nurses out here. It is nice to see them. Really, Boulogne ought to be an English town from the number of English people about.

"We were very disappointed not to receive the promised visit from the Seymour Hicks Party. We had a great crowd in the largest ward, but unfortunately they could not turn up owing to illness."

From Miss H. A. Bruce, at Dieppe:—

"Thanks to all friends at the Hospital and Institution for the Christmas gift, letter, and card. I have been in Dieppe since October 7th nursing at the college. It has been a great experience, calling out all our ingenuity, as at first there was absolutely nothing to use. There is only one other trained nurse here (from St. George's), the rest are V.A.D. and French women. The latter are much better nurses naturally than our own untrained people.

"My first patients were Germans, with terrible wounds, and in a very bad state. The poor fellows were so brave all through most painful dressings. Now I have French patients, and we get on very well; their wounds are nothing to compare with those of the poor German wretches. Of course, that speaks well for the Allies' shots.

"Tetanus seems on the wane—we have not had a single case for two months, no doubt due to the serum given as a preventive measure. We have many cases of frost-bitten feet.

"At first we had a great struggle to get any footing here. We could only speak a few words of French, and also some women who had been passing themselves off as Engilsh nurses had made and left behind them a very bad impression. We were not treated as Allies, I can assure you, or even politely. One day a lady took me to the major, and he condescendingly said I might come temporarily. Of course, that was the thin end of the wedge, and the next thing was, 'French or no French would we stay.'

"So here we are with our own wards. I am glad I brought my instruments with me. At first there only seemed to be one rusty set for the whole place. Things are different now; we even have sterilised dressings. Sister Jolliffe lives and works at the Royal Hotel here."

Miss Gibson (of Miss Kemp's Unit, St. John's Ambulance), writing to friends on the District, says:—

Arc-en-Barrois,
Chaumont, France.

"You have heard of our journey from Sister in my last letter. Our chateau, the hospital, is situated in quite beautiful country. In the village there are several shops. It is great fun going shopping, and they must have benefitted considerably by our presence here. Of course, we had to get small tea pots for our parties. Biscuits are, unfortunately, a fearful price, four times the price they are in London; chocolates and oranges are about the same price.

"I am so glad to have seen this hospital equipped. The medical stores arrived on Friday. Have a splendid supply of everything: thousands of pairs of socks, shirts, etc. Nearly all the pockets contain a present for the wearer, such as writing cases, chocolates, shoe laces, handkerchiefs, often, too, letters from cripples or children who have knitted belts or socks. We have a large quantity of shoes, goloshes, crutches, walking sticks, splints, Turkish squares, brushes, and combs, and hot-water bottles. The Count is going to provide bed tables. The beds are expected to-morrow. The French military will then come to in-

spect, and we hope to be nursing the wounded in a few days.

"Lady Scott is with us, and works very hard, helping to unpack stores. The kitchen staff are V.A.D.'s, and are very good, indeed, and provide excellent food. We can get hot water from the copper for our bottles and to wash in. We are allowed foot baths, for which we are very glad, and sometimes a fire in our bedrooms. We burn wood only.

"I trimmed 21 lamps to-day, and, being Sunday, only the necessary ones were done. Seven of us are going on day duty and five on night. Miss Kemp is Director, and will go with the ambulances to fetch the wounded. She will also have to give a report of each patient every five days to the French military authorities."

Miss Hepburne (of the Institution), writing from Versailles to Matron, speaks of the pleasure the Christmas gift and card gave to all.

"At our Christmas Eve supper all the Guy's present toasted all our friends at both the Hospital and Institution, not forgetting the old hospital itself. We all, sisters and patients, spent a very enjoyable Christmas Day here. Carols in the early morning; after breakfast Princess Mary's gift was presented to each man by the M.O. (most of them have been sent back home for safety, also the King and Queen's card). In the afternoon there was a concert and the usual English Christmas dinner, and each man was allowed two bottles of stout. Matron gave the sisters a tea in the hall at 4 o'clock It was a glorious day, frosty and cold, with brilliant sunshine. We do get such lovely tints in the sky here.

"We are very slack now, and were hoping to get the 96 hours leave granted to the medical and non-commissioned officers. However, Matron told us at a meeting to-night that no leave was to be granted to us. We had not thought of such a thing as leave while on active service until we heard of others actually having it, so now we are naturally very disappointed. As we are not busy, Sisters Brown, Hickman, and I spent a half day in Paris.

"Miss Sidney Browne is visiting all the hospitals, and was here yesterday. She presented the fur cape from Queen Alexandra to one of the Regular Sisters who has lately joined us. Unfortunately the Civil Hospital Reserve are not to receive them."

The many friends of Miss Lear (late Esther Ward) and Miss Ripley (late Lazarus Ward) will be glad to hear they now have plenty of the nursing work they went abroad for near Dunkirk. From the post card received last week the conditions and surroundings are reported as terrible: bad enteric patients lying on straw, hardly any water, old patients crowded together, no nursing appliances. They are well.

Miss Gladys Stone has joined the Versailles No. 4 Hospital:—

"We were all very pleased to be remembered by the old hospital at Christmas; it came as a delightful surprise. I have changed my work and come into a building at last. It seems odd after having had a large field with 11 tents and 142 patients as one's ward to come to a room and stand in the middle and and be able to see all round and every patient at once. We are all very envious of the people going home on leave, but I do not think there is much chance of the sisters getting away."

Miss Muriel Bartlett, writing from Malo les Bains, January 12th:—

"Please thank all at home for the handkerchiefs and Christmas remembrance. I think that it must be far harder to work at home than out here, for here you feel you are on the spot and know how things are going. It is very nice to constantly meet Guy's people here. Our hospital is the annexe of the Hotel Belle Vue, and is situated on the sands. We have had a good many visits from Taubes, which are none too pleasant. It is marvellous to see the height they can fly."

Miss Leggoe and Miss Masters write :—

British Red Cross,
Headquarters, Boulogne.

"We came out in September and were sent through Paris to Laversine. Our hospital was Baron de Rothschild's chateau, beautifully equipped and with lovely grounds. Our patients were nearly all French. They were well looked after and had every comfort. We had only to ask for things required and we got them. Our next move was to the Australian Hospital. Before the storms came we were a Field Hospital, nearly all the men were under canvas, but now they are billeted at the two nearest hotels. At first we did all our nursing by candle-light; now electric light is put in."

Miss Sharwood reports that No. 1 Hospital is stationed in the quaintest place imaginable—a small fishing village which they have practically commandeered. the only inhabitants being a few fishermen and ourselves :—

"It seems such ages since we left St. Thomas's Street, indeed, hardly possible that we were ever there. I have been separated from the five Guyites twice, but now rejoined them. Among other things I have been on station duty. It was very arduous, but I shall never forget the trains packed full of poor chaps in all stages of misery, wounded and sick, and one could do so little for them. We have come across so many Guy's men, who all seem to be doing their best for all around. The hospital should be proud of them."

Letters from Misses Mann and Waters, No. 1 General Hospital, British Exped. Force, report that the five who left Guy's together have so far worked together (Misses Owens and Mann, from the Institution, Misses Prince, Waters, and Sharwood). Miss Banbury has now joined them, and two other sisters, and they are very glad of more help. Miss Finnis is in charge of the theatre :—

"The hospital is now established at a pretty little place, pretty, that is, when fine, which is very seldom. We managed (says one letter) to travel about a good deal at first, but now have joined our own unit, and are under the same roof. I think ours will be quite the biggest hospital out here, in fact, we occupy the entire town. Hotels are not ideal places to nurse in. Ours looks quite sporting filled with Cecil Aldin's pictures, in fact, the French people seem very fond of them. Of course, 'l'eau chaude' is never hot, and the fireplaces are not made for fires, but those are trifles which the charming display of white paint counteracts. Whatever else is lacking we always have plenty of mirrors; they are quite typical of France."

News from No. 12 Ambulance Train, British Exped. Force, comes from Miss G. Allen :—

"This life appeals to me: I love travelling about, and I am very fond of my train. It is the last new one, and the only Engilsh one out *yet*. It is perfectly ideal for nursing on—there are 11 wards with 20 beds each (real beds with mattresses), a theatre, and electric light; as the train is corridor from end to end it simplifies the nursing very much. It is a very irregular sort of life; up very late some nights when we load late. We usually get a rest on the upward journey. It is wonderful, too, how much one can do to make the patients comfortable on a short journey, and we often have them on board all night. The three sisters working with me are from Bart.'s—very nice girls."

Two cases treated with Phylacogen.

The following notes of two cases I have recently treated with Phylacogen may be of interest :—

CASE 1.—C. S., female, aged 51. Unmarried, tailoress by trade.

For some five or six years has had sharp attacks of pain in various joints—apparently typical "flitting pains" - but says she has never had rheumatic fever. For twelve months wrists and ankles have been continuously affected—walking and movement of wrists causing pain. Much limitation of movement.

In September, 1914, went to an English spa for a course of treatment. General health improved, but the joint condition worse on her return.

On examination.—December 12th, 1914, both wrists show periarticular swelling; right wrist nearly completely fixed; typical fusiform swelling of fingers and ulnar deviation at both wrists. Complains of pain, especially in right wrist. Ankles painful. The patient walks "like a cat on hot bricks"—very gingerly. Left ankle has movement very limited, foot flat and apparently forced upwards between the two malleoli. Pain in both feet and ankles on movement. Knees and shoulders creaked slightly, and have been painful, but they are affected much less than ankles and wrists.

On December 14th, 1914—1 c.c. Rheumatism Phylacogen injected subcutaneously, and daily injections were given from this date, increasing by 1 c.c. daily.

On the third day, December 17th, improvement was obvious in wrists, both in diminution of swelling and increase in range of movement. Reactions caused were slight until the fifth day, when there was considerable fever with headache and malaise lasting a few hours.

8th day, December 22nd. Practically no reaction after the dose of 9 c.c.

9th day, December 23rd. 5 c.c. given.

December 24th. Patient was allowed to sit up out of bed, and the next day she went out.

December 28th. There is less swelling round the wrists—which can both be fully flexed passively though with some pain. The fusiform swelling of the fingers is much less marked. Active and passive movements of ankles nearly normal. Gait still abnormal.

Patient is to do simple exercises, such as rising on the toes, flexing and extending wrists, etc., for twenty minutes night and morning, and her sister also applies a very amateur form of massage for ten minutes a day to ankles and wrists.

January 16th, 1915. Five weeks from commencement of treatment.

Full flexion of wrists passively. Two thirds of full activity. Practically no pain. No fusiform swelling of fingers—ulnar deviation less marked. Some swelling of wrists still visible. Gait improved. Can walk some miles without pain. Occasional aching results if she walks far but only slight and infrequent. Can sew with ease. General health very greatly improved—says "life seems quite different," and is told by her friends she appears ten years younger.

CASE 2. M. P., male, aged 50, clerk. First seen December 19th, 1914. When he had a large broken carbuncle below the angle of his right scapula. Has had several others before, the last being four months ago. Has had several attacks of gout. Urine shows no sugar. The present carbuncle has much induration around it and is very painful. There is a small infected spot on the right shoulder. General condition fair, but some nausea and malaise. Fomentations applied four hourly.

December 22nd, 1914. 1 c.c. Mixed Infection Phylacogen given subcutaneously.

December 23rd. 2 c.c. M. I. P. given.

December 24th. 3 c.c. M. I. P. given. The ulceration has not progressed and the "core" is looser and cleaner. General condition improved.

December 26th. 3 c.c. M. I. P. given.

December 28th. 4 c.c. M. I. P. given. Marked reaction followed—vomiting and headache lasting a few hours.

December 29th. 5 c.c. M. I. P. given. Marked improvement. Induration almost nil, good discharge from "core" healthy granulations. General condition very much improved.

December 30th. 2 c.c. M. I. P. given. The last injection, no discharge at all—ulcer quite clean.

January 3rd and 6th. Fomentations have been used throughout, ulcer healing rapidly, no pus, no induration.

January 13th, 1915, ulcer completely healed, some blueness of skin around but otherwise a healthy scar.

These two cases show well the use of phylacogen in what are usually very tiresome cases. Without it the first case—one of rheumatoid arthritis—would in all probability have gone from bad to worse. None of the ordinary treatments had been of any avail.

The second case—that of carbuncle—was saved much discomfort, and was able to resume his business within three weeks; indeed, he might have done so in ten days. His last carbuncle had taken over six weeks to cure, and had caused him a great deal of suffering and left him very "run down." Both the patients are now following their usual occupations, and both state that they feel better than they have felt for a long time.

HAROLD WEBB.

With the A. V. H. in France.

THE Australian Voluntary Hospital was organised by the Countess of Dudley with money collected by private subscription, largely from Australian sources.

We began mobilising at Ranelegh on August 15th, but with the usual delay in collecting equipment, we did not succeed in getting off until August 28th, when we left Southampton by transport—and some of us in Lord Dunraven's yacht *Oreta*—for Havre.

We were excellently equipped with x-ray plant, and all the luxuries of modern surgery. Our personnel—all Australian except orderlies—consisted of 10 surgeons, 24 nursing sisters, and 80 orderlies. We were prepared to take 250–300 patients.

We spent six weary days at Havre, where it was obvious that we were not wanted to put up our hospital. There were no less than seven R.A.M.C. hospitals in the same state as ourselves, waiting for orders. One night we had some excitement in the form of a Uhlan scare. At 2 a.m. we got orders to pack up immediately and stand by. In half-an-hour we were all sitting on our valises, but a little later we were told to unpack again; the Uhlans turned out to be some of our own Cavalry.

On September 4th we arrived at St. Nazaire by the transport *Victorian*, on which I found Hopkins, Gwyn-Davies and Jamie Stuart, who at that time were unattached to any unit. We were lucky enough to secure the only private hospital in St. Nazaire, and behind this was a school-house with six large rooms in the form of an L, which made an excellent series of wards. In addition, we pitched our camp hospital in a wooded plot of sandy ground next to the Public Gardens—a prettier site for a camp one could hardly wish for.

We did not have to wait long for patients, for wounded began to arrive next day. The poor fellows were in a sorry state, many of them had been five or six days on the journey, and some of the wounds were in a very bad condition. It was difficult to realise that a human being could suffer so much pain and survive. I never before realised the powers of endurance and recuperation of the healthy young adult. It must not be thought that I am blaming any of those who had charge of these men on the long journey down—the men themselves all said that everything that could be done had been done, but just at that time arrangements were not perfected, and the number of wounded was larger than the medical staff could cope with. Things are very different now. Most of the men stood their pain like heroes, but just a few gave way badly and showed up the bravery of their comrades by contrast. But they were not all faint hearts who gave way to the pain, and I am sure that some of them were brave men whose nerve and resistance to pain had been absolutely shattered by their dreadful experience and sufferings. I remember one poor Scotchman who looked anything but a faint heart, who had an extremely painful pelvic wound and must have suffered agonies on the journey down. I gave him an injection of morphia, and he cried like a baby when his skin was pricked; he simply couldn't stand any more, and his brave spirit, equal to that of any of his comrades a week ago, had given place to the weakness of a child. I saw many instances like this at St. Nazaire, but very few at Boulogne where the journey of suffering is much shorter.

I was able to watch the change in some patients whose suffering one could not completely relieve. A certain young lieutenant arrived one day in my wards with a very bad and grossly septic fractured femur. The wound was cleaned up as far as possible in the theatre but it had to be dressed twice a day, and it was an extremely painful business. His pluck and grit in bearing the pain struck me very much. The leg, however, was a hopeless limb, and the pain got worse and worse. On the sixth day after admission the limb was amputated just below the hip and the patient died four days later. Well, I saw this patient change from a brave man to one with less resistance to pain than a child, so that if one had only seen him during the last five or six days one would have felt sorry indeed for him, but one could hardly have admired him.

At one time I had about thirty Germans under my care, most of them badly wounded. They were wonderfully good patients and I hardly heard a groan from them during the most painful dressings. I think few dressings are more painful than that of a bad compound fractured

femur, and there were a number of these among my Germans. For these cases I nearly always used the Scotch sheet and long Liston splint without an attempt at extension, as our folding camp beds did not admit of extension apparatus. Now we have 150 iron bedsteads, and Hodgen's splints, etc., can be used. But if extension cannot be used—and in many circumstances it cannot—there is no doubt that the Scotch sheet and long Liston makes a very comfortable way of fixing the limb and greatly simplifies the dressing of these troublesome cases. The method is this:—a sheet is folded or torn so that its width will reach from the heel to the great trochantes of the femur, the lower part of the padded splint is then rolled up in the sheet until about eighteen inches of the sheet remain free, the splint is then laid in position and the free end of the sheet is passed under and around the limb suitably padded on the outside with cotton wool, the sheet is drawn firmly over the ledge of the splint from below upwards and fixed by a row of safety pins. A binder round the chest fixed the upper part of the splint which of course reaches to the axilla.

To return to our Germans: they were mostly of the farmer class, placid peaceful-looking fellows, splendidly built and in the prime of life. They were pathetically grateful for what was done for them, and it really seemed as if they had never had decent treatment before—certainly they had not been led to expect it at our hands. The wounds, as you are probably tired of hearing, were chiefly due to shrapnel, or "scrapnel" as the Tommies call it—and not a bad description either. By the time the patient reaches the base hospital the wounds are nearly all septic, many of them grossly so; I have taken bits of clothing and green grass out of a shattered thigh seven days after the man was wounded. No wonder a certain number of our patients developed tetanus—twelve cases in ten weeks at our hospital. Altogether I saw or heard of forty cases of tetanus during the six weeks we were at St. Nazaire; of these forty cases ten recovered, but this is a much higher proportion of recoveries than the average. The general and depressing view seemed to be that treatment had very little effect and that the cases fell into two classes—those with a short incubation and rapid onset of general convulsions and those with a long incubation and trismus as the chief or only symptom. The former practically always died in one to three days, the latter frequently recovered; nevertheless, we nearly always give antitetanic serum intrathecally, and use chloral, chloretone, morphia, or magnesium sulphate (intrathecally), to control the spasms. The badly septic wounds, on the whole, do wonderfully well when treated with the freest possible drainage and daily irrigation with weak hydrogen peroxide; we have quite come to the conclusion that weak peroxide is the best lotion for irrigation in these cases, and fortunately there seems to be an abundant supply.

The efficiency of our X-ray department is one of the things of which we are proud; it is always in working order, and its results are invaluable. Most of our cases have to pass through the hands of Captain Herschell Harris, who controls the department, and he is a very hardworked man indeed, and, most fortunately, nothing is too much trouble for him.

At first one's inclination on seeing a bullet by the X-rays was to operate and get it out, but it is by no means always advisable to do this. In many cases it is much better to clean up the wound as far as possible without further injury to the damaged tissues, and to do the bullet hunting later on when the wound and the patient are in a better condition. One of my patients had a badly shattered arm containing six pieces of metal including two shrapnel and one rifle bullet. The front of the forearm was a mass of torn muscles, and the whole thing was very septic. Several pieces of rubber tubing were put in, and the whole arm was given a daily bath of saline and weak peroxide, 2 to 3 vols, for an hour or so. It cleaned up in a remarkable way and the pieces of metal were easily removed subsequently, their positions being indicated by sinuses.

On October 25th we had orders to move to Boulogne, which had taken the place of St. Nazaire as the military base. We could hardly expect to get such ideal quarters for our hospital as we had enjoyed at St. Nazaire, and we did not get them. We were allotted a hotel at Wimereux, some four miles out of Boulogne, and standing in a very exposed position.

We had no sooner arrived and begun to put our hotel in order and to erect the canvas part of our hospital than we were asked to receive nearly 200 wounded, most of them really bad cases. They were quite the most severely wounded lot of men we had had, and for the next ten days there was rest for nobody among the hospital personnel. At one time there were five cases of secondary hæmorrhage waiting their turn to come into the theatre, and Captain Gardner tells me that he had to tie three successive femoral arteries. One had no time to take any interest in what other people were doing, we each had our own wards and had no need to go outside them for bad cases. In one ward of 14 beds I had 4 bad compound fractured femurs, 3 hæmothoraces, 2 cerebral cases with hæmiplegia, a man shot in the buttock with paralysed bladder, one shot through the kidney with hæmaturia, one shot through both knees with the left joint infected, an amputated thigh which reached us in a septic condition and had a secondary hæmorrhage.

We all took our turn in the operating theatre, and for some days there was a perject orgy of surgery which is not pleasant to look back upon. Nevertheless, most of these bad cases did surprisingly well—nearly all the men seem to have "wonderful good 'ealing flesh." As an instance I may quote one remarkable case. The patient had a very septic wound two inches above the symphysis pubis where he said he had been struck by a piece of shell. On X-ray examination two pieces of metal were seen in the left thigh. At the operation a piece of metal nearly an inch cube was removed from the outer aspect of the thigh about four inches below the great trochanter, and another smaller piece from the inner aspect of the

thigh at about the same level. It was possible to follow the tracks of these fragments from the wound of entrance, and a piece of one inch rubber tubing, about 14 inches long, was passed from the entrance wound downwards over Poupart's ligament, *behind* the femur to the outer wound, and a half-inch rubber tube was also passed from the entrance wound to that on the inner side of the thigh.

It seemed remarkable that these large fragments could pursue such a long and deep course among important structures without injuring any of them. The sepsis cleared up very quickly, the tubes were divided in the middle and shortened gradually, and the patient did very well. I could quote numerous individual cases of interest, but I am not writing an essay on "wounds in war," and most of us have read articles *ad nauseam* on this subject in the medical journals.

It will be readily understood that the most laborious part of the work at a base hospital is the large number of heavy daily dressings, but the rapid improvement under careful treatment that most of these bad cases undergo, makes the work very satisfactory, and one is well repaid for one's trouble by the gratitude of Tommy Atkins—an excellent patient and a very good fellow.

W. R. R.

Papers by Guy's Men.

C. F. Constant: The Localisation and Extraction of Bullets.—*Lancet*, January 16th, 1915.

C. F. Newland-Pedley: Our Army's Teeth.—*Lancet*, January 16th, 1915.

J. N. Fortescue-Brickdale, M.A., D.M., M.R.C.P.: Recent Advances in the relation between Clinical Structure and Pharmacological Action.—Brit. Med. Jour., January 16th, 1915.

W. E. Levinson, M.R.C.S., L.R.C.P.: Lymphocytic Leukæmia.—*Brit. Med. Jour.*, January 16th, 1915.

Arthur J. Cleveland, M.D., M.R.C.P.,: The Accurate Localisation of Foreign Bodies in the Tissues by X-Rays.—*Arch. of Rontgen Ray.*, January 1915.

Arthur F. Hertz, M.A., M.D., F.R.C.P.: The Parathyroid Glands.—*Practitioner*, January, 1915.

Dep. Surg. Gen. A. G. Wildey, R.N.: Ununited Fractures treated by Long Axial Drilling.—*Brit. J. of Surg.*, January, 1915.

O. G. Morgan: The Wounded in Namur.—*Ibid.*, January, 1915.

Arthur W. Ormond, F.R.C.S.: Visual Symptoms in association with Lesions of the Spinal Cord.—*Clin. Journal*, January 13th, 1915.

Thomas G. Stevens, M.D., F.R.C.S.: A Lecture on Ante-Partuns Hæmorrhage.—*Ibid.*, January 20th, 1915.

L. Bromley, M.C., F.R.C.S.: Tumour of the Upper Extremity of the Femur.—Proc. Roy. Soc. Med., Sect. for Study of Dis. of Children, December, 1914.

P. Turner, M.S., F.R.C.S.: Double Retained Testicle in which the Left Testicle was transplanted to the right side of the Scrotum, and the Right Testicle to the left side.—*Ibid.*, December, 1914.

——Double Undescended Testicle; Right Testicle transplanted to the left side of the Scrotum.—*Ibid.*, December, 1914.

——Seasonal Enlargement of the Parotid Glands.—*Ibid.*, December, 1914.

Thomas D. Lister, M.D. Lond., M.R.C.P.: The After-Treatment of Artificial Pneumothorax.—*Universal Medical Record*, December, 1914.

Alan H. Todd, M.S., F.R.C.S.: Probable Injury of the Crucial Ligaments.—*Ibid.*, Clin. Sect., December, 1914.

John D. Malcolm, F.R.C.S., Edin.: Intestinal Fistulæ made with a view to facilitating recovery from certain conditions which may follow Abdominal Operations.—*Ibid.*, Obst. and Gyne. Sect., December, 1914.

H. L. Eason, M.D., M.S.: Confluent Tubercle of the Iris.—*Ibid.*, Sect. of Ophthalmology, December, 1914.

R. A. Greeves, M.B., B.S., F.R.C.S., and another: Multiple Cysts in the Anterior Chamber derived from a Congenital Cystic Growth of the Ciliary Epithelium.—*Ibid.*, December, 1914.

W. M. Mollison, M.C., F.R.C.S.: Brain of a patient shown to the Section last year: the patient having died some weeks after operation.—*Ibid.*, Otol. Sect., December, 1914.

——Syphilitic Ulceration of External Auditory Meatus.—*Ibid.*, December, 1914.

W. Sampson Handley, M.D., M.S., F.R.C.S.: Inoperable Carcinoma of the Rectum becoming Operable under Radium Treatment.—*Ibid.*, Surg. Sect., Sub.-Sect. of Proctology, December, 1914.

R. Lawford Knaggs, M.D., M.C., F.R.C.S.: A contribution to the study of Ossification in Sarcomata of Bone.—*Brit. Journ. of Surgery*, January, 1915.

Reviews, etc.

Notes on Dental Surgery and Pathology. By T. W. Widdowson, L.D.S., R.C.S. Eng. (John Bale Sons & Danielsson, Ltd.). Price 10/6 net.

This book, to quote the author's own words, "is intended as a ready work of reference for the busy practitioner and a note-book for students." Although printed in a more or less tabular form it is rather more than the above description implies, almost, in fact, a concise text-book on the subject. The contents are divided into twenty chapters and the book, including the index, contains 345 pp. In between each page of text is a blank leaf for note making. This is both advantageous and disadvantageous. Advantageous because the book is primarily intended for students, and few will deny that note-taking and sketching are a great incentive to memory, disadvantageous because of the extra bulk and weight. However the advantage certainly outweighs the disadvantage.

The printing is clear and of a size pleasant to read; the paper of a dull kind that does not irritate when reading by artificial light.

The illustrations are mostly diagrammatic as in the author's opinion these are better from a teaching point of view than are sketches. In this we are in agreement with him, although figs. 43 and 48 will bear improvement in this respect.

One rather objectionable factor is a rather too frequent mention of proprietary articles, *e.g.*:—

p. 19, Allen & Hanbury's, bottles.
p. 25, 95, Hill's gutta-percha.

p. 26, 104, Ash's or S. S. White's fibre.
p. 87, Fleming's tincture of aconite.
p. 99, 102, Fletcher's artificial dentine.
p. 124, 142, Calxine.
p. 143, Antikamnia.
p. 164, Euthymol.
p. 279, Parke, Davis & Co's., adrenalin chloride solution. Horlick's milk.
and many others.

On page 22, in the chapter on the care of deciduous teeth, the author advises, apart from brushing, the use of floss silk and quill tooth-pick. A little hard on a weary mother of four or five young children, t.d.s.

On page 90, under the exciting causes of caries the humoral theory might well be omitted.

On page 159, under the article on pyorrhœa, one of the causes mentioned is the misuse of orthodontia appliances. It would, perhaps, be as well to add *badly-fitting* orthodontic appliances.

In the chapter on Odontomes Bland Sutton's classification is given. It is unfortunate that the classification of Warwick James, Gabell and Payne was not ready for insertion. Attention might also be drawn to the explanatory text beneath figs. 120, 125, in which Sir John Bland Sutton and Sir Christopher Heath, are described as ordinary mortals.

The list of "Affections which may arise from Dental Neglect" might be curtailed to a slight extent, *e.g.* the deletion of Pancreatitis and Progressive Muscular Atrophy; also the thirteen affections of the eye which are enumerated might well be cut down to five or six.

Chapter xx. "Swellings occurring in and above jaws" is tabulated in a remarkably clear and concise manner, and although only three pages in length serves its purpose to a student in a better manner than many a bulky volume confined entirely to this subject.

The article on sterilization might with advantage be amplified, and a chapter on X-ray work would also be extremely valuable.

The above are a few criticisms on a book which we can with pleasure recommend to all students as a valuable aid for examination work, and to all practitioners as a great help in the course of every-day practice.

A Text-book for Midwives. By John S. Fairbairn. (Hodder & Stoughton.) Price 10s. 6d.

This is a most excellent book, and does not need the author's apology for adding another text-book to the many already provided for midwives. Dr. Fairbairn aims at meeting the aspirations of those women who are not content to learn like parrots, but who wish for a thoroughly good theoretical education in a profession the practical side of which is for them necessarily circumscribed. The instruction is given in such a way as to make most interesting reading, and the book is illustrated by numerous and excellent pictures and diagrams, so that it can hardly fail to be of absorbing interest to both the trained midwife and the student.

A Manual Diseases of the Eye. By Charles H. May and Claude Worth. 1915: 4th Edition. (Baillière, Tindall & Cox). Price, 10s. 6d. net.

The present Edition of this well know text-book on Diseases of the Eye—while fully maintaining the high standard of previous editions—has been thoroughly revised and new matter added.

The most conspicuous addition is a well-written chapter on Colour-Blindness by Mr. C. Devereux Marshall, which gives a lucid account of the modern theory propounded by Edridge-Green and includes a description of the Lantern-Test for Colour-Blindness.

The book as a whole is remarkably free from mistakes, and contains a suprising amount of information We do not share the author's evident contempt for the Tonometer, which we think a very valuable addition to the Armamentarium of the ophthalmic surgeon, and indispensable for the keeping of accurate records of cases of Glaucoma.

The chapter on Glaucoma includes a brief account of the newer operations of Herbert and Elliott. We think however that the book would be improved if a separate chapter were devoted to the important subject of Secondary Glaucoma, and the various conditions leading to this complication grouped together in this way instead of being scattered throughout the book.

As in previous editions the coloured illustrations are a feature of the book. An appendix containing the visual standards for admission to the various Public Services should prove useful to the practitioner.

A useful chapter on Therapeutics, near the end of the book, includes a brief account of such modern Therapeutic Agents as Carbon Dioxide Snow, Ionisation, etc., as far as they are applicable to Eye Diseases, while a practical and concise account of Vaccine Therapy will be found in a separate chapter by Dr, S. H. Browsing.

We can cordially recommend the book to those in search of a practical and reliable guide to the study of Diseases of the Eye, who have not the time to consult the larger works.

Births.

POOCK.—At Clareville, Dorchester, Dorset, on January 15th, to Mr. and Mrs. Graham Poock, a son.

GRAVES-MORRIS.—On January 11th, the wife of H. W. Graves-Morris, L.D.S. Eng., of Malvern House, Luton, of a son.

Death.

FITZMAURICE.—In British Somaliland, Alexande Lindsay Fitzmaurice, M.B., B.S., Colonial Medica Service, eldest son of Dr. Richard Fitzmaurice, of Lindfield, Hayward's Heath, aged 29 years (by cable).

W. E. T.

GUY'S HOSPITAL GAZETTE.

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Passim.

THERE was a long list of successful Guy's candidates at the recent Conjoint Examination; 45 men presented themselves for some part or parts of the examination and 24 men qualified. In Medicine, of 25 candidates 21 passed—84 per cent.; in Surgery, 21 out of 28 passed—75 per cent; and in Midwifery 17 out of 20 passed—75 per cent. The results reflect great credit on the discrimination of the examiners, the teaching and practical work of our school and the ability of our men to assimilate the knowledge and experience offered to them. Everyone connected with the Hospital will be pleased that eight of the successful candidates have accepted House Appointments for three months or more, and therefore the emergency scheme of appointments is not yet in operation. They were all badly needed, for even now we are working with the minimum number of men compatible with efficiency. It is the duty of a large hospital to use every available method of investigation and research for the benefit of patients under its care.

An over-worked House Officer is liable to neglect what at one time may appear to be unessential details, but we all know that details have a way of becoming very important in the course of disease or injury. More errors in diagnosis arise from incomplete examination than from errors of observation. A letter appeared in the *British Medical Journal* on February 6th, from Dr. W. M. Wilson, of the East London Hospital for Children, Shadwell, appealing for help to carry on the work of that hospital. All the regular methods of obtaining resident doctors have been exhausted, and unless help is forthcoming a large part of the hospital must be closed; a serious calamity for the sick children of the neighbourhood. We must not allow Guy's to be faced with such a problem as this. If a small proportion of the junior qualified men remain here for a few months only, we can carry on efficiently without neglecting the Naval and Military services, which are receiving a very high percentage of Guy's men.

THE new Residents took up their duties on February 1st—C. P. Symonds (Dr. Hale White's H.P.); C. H. L. Harper (Dr. Shaw's H.P.); W. E. Tanner (Sir A. Lane's H.S.); P. R. Boswell (Mr. Dunn's H.S.); A. F. Rook (Junior Charity) and R. Sells (Ophthalmic H.S.). A. Wills (H.P. to Dr. Fawcett and Dr. Beddard) has been elected President, and A. B. Danby (Sir A. Fripp's H.S.) Vice-President of the Residents.

The strenuous work at a time of great emergency of the off-going Residents is a source of inspiration to us all. They rose magnificently to the occasion, and we congratulate them.

E. D. Scott has gone to a hospital in France; C. H. Gould, a caricature of whom from the pen of Mr. Stanley Cock appears in this issue, is a surgeon in the Navy; W. H. Ogilvie was married on Tuesday (see photo in the *Daily Mirror*, January 10th), and will shortly proceed to a hospital in France. J. F. Venables, Lieutenant R.A.M.C., sailed for France on Friday. Good luck to them all!

THE Governors have authorised the purchase of equipment desired by Dr. Lindsey Locke for the Medical Radiography Department at a cost of £300.

A foreman has been appointed to the Orthopœdic Workshop to supervise the making of surgical appliances.

NEWS has been received from the Colonial Office that A. L. Fitzmaurice, whose obituary appeared in the last GAZETTE, died on January 11th, from ulcerative colitis after a seventeen days' illness.

ANOTHER letter has been received from H. R. Mullins, protesting against our *fulsome flattery*; we may only publish extracts.

He informs us that Major E. T. E. Hamilton is in charge medically of the Expeditionary Force to Swapamund. H. A. Moffatt is Casualty Surgeon to the same force.

THE War Office have very kindly permitted us to publish an interesting memorandum on "Trench Foot or so-called Frost-bite" in this issue of the GAZETTE.

IT will interest you to know that, according to a letter which appeared in the *Standard*, the telephone probe has been in use at Guy's for seventeen years.

WE have been unable to find a reply, suitable for the GAZETTE, to Dr. Walker's query; however, we have collected a few stories during the week.

An army recruit was sent from Guy's to a Convalescent Home. He discharged himself from the Home as he objected to eating cold ground rice pudding and jam for Sunday dinner. We hope his appetite will not be so fastidious, if ever he reaches the trenches.

LETTER received by an O.P.O. in the Surgery: —

> "Please Sir, will you kindly see to my child's ear and head as I cannot come myself as I have increased a new baby."

IN the X-Ray room at a needle-sitting, R.S.O.:—

"I heard from Dr. Morgan to-day Sister. He tells me they are dropping bombs on Dunkirk."

Boro' Lady: "Did you say the *Dun-Cow* Doctor?"

[May we, for the benefit of the fair sex, and others, point out that the *Dun Cow* is a well-known public-house near the Hospital?]

CANDID.

H.P. in Surgery:—

"What's the matter with you, mother?"

"Well, Sir, Dr. Shaw said I'd got an abdominal stumer."

WE much regret that there is no Clinical Lecture in this GAZETTE owing to a misunderstanding for which the Editor is alone responsible. The next issue will contain an interesting illustrated lecture by Mr. Charters Symonds on "Chronic Abscess of Bone and its Treatment."

Stray Cases of Interest from the Ear and Throat Department.

By W. M. MOLLISON, M.C., F.R.C.S.

A case of total unilateral deafness due to concussion(?) of the internal ear.

A trooper in the Dragoon Guards was, with a companion attacked by a number of enemy cavalry. While endeavouring to escape, the patient's companion was killed, while the patient was shot through the left side of the neck. The bullet entered about two inches behind and slightly below the tip of the left mastoid process and emerged from the left cheek, tearing it open extensively. (With a certain amount of pride the man pointed out that the cheek had healed without any medical assistance!) In its course the bullet must have passed deep to the sterno-mastoid, perhaps grazing the deep aspect of the tip of the mastoid process, deep to the angle of the lower jaw through the pterygoid region, and so out through the cheek. The scar in the face was perfectly healed, though depressed.

The tympanic membranes were normal, but the left ear was absolutely deaf, as was proved by different tests; with Weber's test the fork was heard in the sound ear, Rinné's test was negative, the fork being heard through the bone by the sound ear. While reading aloud there was no raising of the voice when Bárány's noise apparatus was pressed into the left ear, and marked raising of the voice when it was pressed into the right ear. This test absolutely excludes any suggestion of malingering, as the voice raising is quite involuntary and is not realised by the patient. As there was not obvious damage to the external or middle ear, the lesion must have been in cochlea or brain, and in the nature of a concussion, because, of course, there was no damage by the bullet itself. Perhaps the jar caused hæmorrhage into the cochlea, or, perhaps, there was concussion of the eighth nerve.

Section of a tonsil showing the presence of cartilage and bone.

A man of 20, an R.A.M.C. recruit, had a sore throat; during the attack a gland developed in the neck on the left side. He recovered completely from the tonsillitis (never at any time severe), but the gland in the neck remained, varying in size from time to time. During this period Major Layton had had him under observation. The left tonsil was thought to be the probable source of gland infection, and was enucleated. The gland steadily diminished in size after removal of the tonsil. Dr. Nicholson kindly cut sections of the tonsil. Examination of the sections showed the presence of cartilage, and in one part a small patch of bone apparently developing from the cartilage.

The occasional presence of cartilage in tonsils has been known for many years. Reitmann, in 1903, from a large series of cases of ages varying from a few weeks to old age found cartilage in as many as 34 per cent.

It is not yet decided whether the presence of the cartilage is due to embryonic remains of the second arch, or whether it develops as a result of chronic inflammation. This case would favour the former view, as the patient did not suffer from sore throats and was only twenty years old.

A case of fixation of the right crico-arytenoid joint cured by injection of 606.

Alfred S., aged 21, attended Mr. Davies-Colley's Out-patients complaining of a pain in the left side of the chest and hoarseness. No cause for the thoracic pain could be discovered by clinical examination or by X-rays. He was sent to the Throat Department for an opinion on the larynx. On examination the right (sic) vocal cord was found fixed, and this fixation was seen to be due to fixation of the arytenoid, though there was no swelling.

A Wassermann's test was carried out, and gave a weak positive result. The patient was given an intravenous injection of 606, and in a short time his voice was normal, and examination of the larynx showed the right cord moving well.

A case of sudden complete unilateral deafness and vertigo perhaps due to tobacco smoking.

Arthur B., aged 26, was seen on December 17th, 1914, on account of vertigo of sudden onset, combined with deafness in the right ear. The patient is a healthy-looking young man who is awaiting a commission in the Army Service Corps. He had about a week ago a

cold in the head. Seven or eight years ago he strained his heart after a steeplechase. He has been accustomed to smoke about 20 cigarettes a day, and never felt any ill-effects; on the other hand, pipe smoking has always affected him, making him feel "weak in the knees." As far as he is aware he heard perfectly well with the right ear previous to the present attack.

One week ago as he was getting on to a tram he suddenly felt very giddy; he managed to get in, but on sitting down he experienced a tingling sensation which, starting in his feet, passed up to his head, and he felt as if he were going to faint; he did not do so, but felt very giddy, and reached home with help. He walked "just like a drunken man." He noticed, too, at the first that he tended to walk towards the right, but this tendency he soon overcame. He had no nausea. At the same time (one week ago) he noticed that he was deaf in the right ear, and had some tinnitus which was a singing or a rushing.

On examination, on December 17th, the patient was still distinctly giddy; he could not stand steadily on one foot, and when he tried to do so he felt more giddy. His blood-pressure was 128 mm. of mercury.

The tympanic membranes were normal in appearance, there was no abnormality of the nose, pharynx, or naso-pharynx; the Eustachian tubes were patent. The hearing was normal in the left ear; in the right ear he heard nothing. With the noise apparatus in the left ear he heard no words spoken into the right ear or into a long metal speaking tube. With Weber's test the fork was lateralised to the left. Rinné's test gave a negative result.

Vestibular apparatus, there was slight spontaneous nystagmus to the left, but very slight. Syringing with cold water gave rise to good reaction on the left side, contra-lateral nystagmus being produced and the patient feeling giddy. Syringing the right ear also gave rise to nystagmus, but much less intense, and the patient scarcely experienced any giddiness.

The result of this test, therefore, was not very definite; the most one could say was that the labyrinth of the affected side reacted less quickly than that of the sound side. He was given some potassium bromide.

Ten days later the patient was seen again. The vertigo had now entirely gone, indeed, it had done so two days after the previous interview, and he noticed he could now stand on one foot fairly easily. He thought he could hear slightly with the right ear. The result of the testing now: with the noise apparatus in the sound ear the patient hears occasional words spoken into the right ear; with Weber's test the fork is referred to the sound ear; Rinné's test gave a positive result—through the air he heard a^1, C, and, perhaps, G. The upper tone limit was very greatly depressed, a note of 6,900 vibrations a second being the highest heard.

Seen again two days later; the hearing found the same. Rotation tests were carried out; all the canals on both sides reacted, but on both sides the reaction was sluggish. After ten turns the vertigo was only momentary, and the nystagmus lasted only a few seconds. Blood taken for Wassermann's test gave a negative result.

Seen again on January 15th; very slight giddiness, but he had stopped the bromide. Still practically deaf, though he heard some forks slightly, but only occasionally caught a word spoken loudly into the ear. No cause apart from smoking could be discovered.

Tuberculous ulceration of gums and palate.

Eliza M., aged 35, attended Guy's Hospital complaining of a sore mouth, February, 1914. There was extensive ulceration of mucous membrane over the upper alveolus; this ulceration involved the whole of the gums from one side of the mouth to the other. There were, too, some small pitted ulcers on the hard and soft palate. The nose, naso-pharynx, and larynx were and are normal. The patient was treated with injections of tuberculin for some time and was given arsenic, but no improvement followed. She was then admitted to the hospital, and the whole of the ulcerated surface was removed from the gums.

Dr. Nicholson cut sections from the ulcerated parts removed; these show very beautifully large giant cells typically tuberculous, but though many sections have been examined, no tubercle bacilli can be found.

The case is one of lupus of the gums and palate, and it is well recognised that the tubercle bacilli are extremely few in number in the tissues affected by this disease.

Treatment with tuberculin made no appreciable improvement; but after removal of the ulcerated area healing took place very well indeed.

A case of temporary facial paralysis due to acute otitis media.

Richard J., aged 5, was brought to the Out-

Patient Department on account of "his mouth being drawn up" for the previous two days.

He had a complete right-sided facial paralysis. He had had earache for four days and a very slight discharge for two days. The right tympanic membrane was reddened, and Shrapnell's membrane was very red and bulging. Under an anæsthetic Shrapnell's membrane was incised horizontally and pus escaped; the pars tensa was also incised in its posterior lower quadrant. The ear discharged for some days and the facial paralysis gradually disappeared till by February 2nd, when the patient was quite normal again and the otorrhœa had stopped.

Cases of facial paralysis due to acute otitis media are quite unusual. Not more than four cases have been seen during the last five years in the Ear and Throat Department. The cause is, no doubt, pressure exerted on the facial nerve by the pus in the tympanum. The nerve runs in a bony canal with a very thin wall, and occasionally this canal has deficiencies in its bony wall so that tension in the tympanum produces direct pressure on the nerve; it is possible, also, that the inflammation attacks the nerve through the bony deficiencies and gives rise to a local neuritis.

Papers by Guy's Men.

C. A. Achner, L.D.S.: A maxillary splint.—*Dental Record*, February, 1915.

Harold Chapman, L.D.S., D.D.S. Penna.: A case of normal development.—*Ibid.*

Arthur F. Hertz, M.D., F.R.C.P.: The therapeutics of organic extracts.—*British Medical Journal*, February 6th, 1915.

Theo. B. Hyslop, M.D., F.R.S.E.: Internal secretions and the psychoses.—*Practitioner*, February, 1915.

E. T. Jensen, M.B., M.R.C.S., L.R.C.P.: Fear and disease.—*Lancet*, January 30th, 1915.

W. Johnson, M.D., B.S., M.R.C.P., and Geoffrey Marshall, M.B., B.S.: Observations on Thomsen's disease.—*Quarterly Journal of Medicine*, January, 1915.

A. G. Levy, M.D.: The relation between successive responses of the ventricle to electric stimuli and ventricular fibrillation.—*Journal of Physiology*, December, 1914.

E. H. Starling and another: The respiratory changes of the heart in the diabetic animal.—*Ibid.*

N. Mutch, M.D., B.C., M.R.C.P.: The isolation of parahydroxyphenylacetic acid from urine in disease.—*Proc. Physiolog. Soc., Journ. of Physiology*, Dec., 1914.

Human Relationships and the War.

By EVELYN SHARP.

I suppose one of the few lasting effects of the war will be the readjustment of values that has been taking place all the while at the back of the fighting line. Human relationships as well as national ones are in the melting pot, and what may come of it all no one can yet say. But at the end of six months of war it is possible to draw some deductions from what has actually been accomplished; and of women we can fairly say two things—that they have shown themselves extraordinarily resourceful in a crisis, and that they would have done even more effective work than they have done if the State had not been so unprepared, or so unwilling, to make use of the mass of help that women placed at its disposal. For the cynic who said—I cannot find two people to agree whether it was Napoleon or Nietzsche, so it was probably both, perhaps anticipated by Solomon—"Woman is the relaxation of the warrior" so exactly expressed what people (generally not warriors) do want women to be that, whenever war breaks out, she is expected to play down to that level and remain there; though, when some of them do fill this somewhat limited sphere, there is an immediate outcry against the depravity of all women and a demand that something should be done to protect the poor warrior against his relaxation.

When the present war broke out, however, it was immediately seen that the great majority of women had no intention whatever of being anybody's relaxation, least of all their own. A famous actress said to me, the day after war was declared, "I won't knit and I won't scrape lint. I am as capable as that road sweeper of cleaning this street—and the road-sweeper ought to be freed to go and fight." Well, when she found that her offers of road-sweeping did not meet with the encouragement they deserved, she went off and founded, with another famous woman or two, the Women's Emergency Corps, the original intention of which was merely to form a register of women capable of performing any service, from driving a motor omnibus to planting a field with potatoes or speaking five languages, including Flemish; and in a couple of days 2,000 names were enrolled, each carefully investigated in order to exclude the inefficient; and they have continued to pour in ever since.

Now, if the State had been administered on a human instead of an exclusively male basis, this register would have been of the utmost value. Every chauffeur or farm labourer or printer or chemist or accountant or professor or carpenter, who wanted to enlist, could have been set free for this purpose, while his job would still have been done, and some woman, badly hit economically by the war, would have found occupation

and ceased to be a burden to the State. Industries would not have been dislocated and public services would have been maintained at their full strength. To mention only one State department, we should not have had to forego the delivery of letters and parcels and to do without our express messenger service if the country had been prepared to recognise the capabilities of women. Instead of which, all sorts of inconvenience, as well as a large amount of acute distress, has been occasioned simply by ancient prejudices that forbid women to be postmen though they may be telephonists, or to be 'bus drivers though they may forge heavy iron chains. And Members of Parliament, anxious to pay a tribute to the women of the country, are reduced to referring to them in their speeches as though they were doing nothing but knit socks—while little boys of eleven and twelve are being taken away from school to work in the fields without the least effort being made to ascertain whether there are no strong and healthy young women available for the job.

Luckily for the country, the women have not lost time in repining, but have set to work to find things that wanted doing and to do them. It was the women of the Women's Emergency Corps, for instance, who first grasped the importance of meeting the trains that brought the Belgian refugees to London. The drivers of motor cars and the despatch riders, entered on their register, were used to convey the refugees to their various destinations; the linguists went to interpret, and trained social workers went to keep them out of the clutches of the White Slave traders. The work was so obviously necessary that it was finally taken over by the Government—but it was the women who started it. Similarly, the clever idea of preventing waste and husbanding the food resources of the country, now become of paramount importance, originated very early in the minds of the women of the W.E.C.; and their scheme, admirably initiated by Miss Carey, finally became a semi-official concern with a grand name that is now carrying on the work; but it was begun at a time when the men of the State were absorbed in military matters. The same Corps has further been responsible for numerous schemes for relieving unemployment among women; it has opened workshops, started such industries as toy-making, become an employment bureau, for professional as well as other women, who were thrown out of work through the war.

It is impossible within the scope of this article to enumerate a tenth part of the work that has been done by the women's organizations in the past six months. The Women's Co-operative Guild, for one, turned its attention particularly to the coming generation, and at once got out a practical scheme for establishing maternity centres and looking after expectant mothers. The Suffrage Societies, with their splendid bands of organized workers, have carried out an immense amount of relief work. The Woman Suffrage National Aid Corps, besides making a register of qualified women, has organized numerous schemes, including a vegetarian restaurant in Nine Elms where nourishing meals are served at cost price to the very poorest. The cost-price restaurant originated, I believe, with Miss Sylvia Pankhurst, whose extensive relief work in the East End is enough by itself to show what women can do in the way of humane organization. When war broke out and took away thousands of reservists as well as new recruits from that most destitute district of London, thousands of families were instantly plunged into destitution; pawnshops closed, separation allowances were in many instances long in coming, existing relief organizations were overwhelmed with work. The East London Federation of the Suffragettes stepped into the breach, opened milk centres, baby clinics, public nurseries, started a co-operative toy factory and boot factory, employed women at a living wage, provided meals at cost price, and more or less saved the situation and are still effectively carrying on the work. The New Constitutional Society in Knightsbridge is running a workshop for dressmakers out of work, giving them time to go and look for permanent posts, and paying them a living wage. The National Union of Woman's Suffrage Societies, besides doing a great deal of Red Cross work and sending out well-equipped Hospital Units to Servia and France, has done much, as well, in finding employment for professional women and in training unskilled workers. The Actresses' Franchise League has worked hard to relieve distress in the theatrical world; the United Suffragists, an association of men and women, and many Committees of women—the Tipperary League was one of the first—have opened clubs for working women, especially for those who are the relatives of soldiers. The Women's Freedom League, besides running its National Aid Corps, has successfully started a corps of volunteer women police, whose work has been carried out with such ability and tact that I have no doubt it will lead in time to the establishment of an official women's police force.

These are only a few of the directions in which women's activities have been used since the war broke out and dislocated the ordinary life of the country. Out of this welter of relief work I fancy that women's clubs will prove, perhaps, the idea that has really come to stay, because their work is more preventative than remedial, and their need is one that belongs to all time. As long as these clubs do not become centres of instruction and improvement, they are really likely to prove a counter-attraction to the streets and the public house. I do not mean in any way to decry those clubs that do serve the double purpose of recreation and education; they are doubtless needed for a different class of women, but I do not think they get hold of the women who want helping the most, the ones who "go wrong," as it is somewhat humorously called, because they long so desperately to catch some of the colour of life for themselves. For them I think we want to provide cheerfulness and colour and pretty furniture, and the freedom as well as the comforts of club life—not the advantages of a well-organized institution. It was in a club that tries to be one of this kind that a woman said with a

sigh of satisfaction the other day: "I do like this place. It's just like a West End gentlemen's club—with no religious instruction!"

But by far the most important result of women's work during war time will be, I hope, the readjustment of human relations that should follow such an exhibition of public spirit and solidarity. Before the war, human relations, though strengthened in some respects—in the growth of friendships between men and women, for instance—had grown somewhat strained in the course of the long struggle of women for better conditions, better education, better opportunities, for what are vaguely called their rights, in fact. But the war, let us hope, with all its tragedies and its devastating ravages and its inhumanities, will have some purifying effects. And not the least of these will be the recognition that, while man is man and woman is woman, both are by the grace of God also human beings.

Nursing News from Letters received at the Hospital or the Institution.

From Miss F. L. Davies:—

"As you will know, all from the *Asturias* have been on furlough.

"Had hoped to call and see you and thank you personally for the welcome Xmas letter and card and handkerchiefs. It was a very kind thought from all our friends at Guy's and the Institution, and much appreciated.

Sunday, Sister Martin and I spent at Netley, of course we made tracks for the British Red Cross Huts, where we had a very hearty welcome from all the Guy's people, who were very pleased to see us. It was really most interesting, more especially as we met so many of the Tommies whom we brought over on the *Asturias*.

"It was wonderful to see the change in them. One man in particular who was looking so ill and sad on the ship, was so bright and bonnie, it made one happy to see so marked a difference.

"The only regret we have on board is that unfortunately we pass on our patients so quickly that we are never able to see a case through.

"When first on board the ship I was on the officers' deck and theatre; for the last two months I have been on night duty in charge of a small ward of 84 cots! There is only one orderly and myself on duty, so there is plenty to do—but it is a pleasure, I love my work.

"Sister Martin and I may be leaving the ship after this voyage. We shall be very sorry, but there is one thing, we have not excelled as sailors (though much better than when we started), and for that reason shall be glad of a change."

Jan. 1915.

Miss Cheetham, who was trained at Guy's, and a member of the Q.A.I.M.N.S., and Matron in charge of No. 12 Hospital, Rouen, writes Jan. 10th:—

"No gift I received at Christmas pleased me more than the one I received from my old Hospital, and the card will be carefully treasured as one of the souvenirs of this active service. I have several Guy's Nurses now on my staff transferred to me from No. 6 General. They are Misses Moriarty, Hiles and Cosby. Miss Strange left for Havre just before Christmas.

"We also had Mr. Popham as our Chaplain, and we miss him very much. He was the life and spirit of the place and so good with the men, and organised concerts and entertainments for them. We want men like him badly."

From Miss F. Broome (Guy's Institution).

Château d' Annel,
Oise, France,
January 21st, 1915.

"It seems months and months since I left England, although the days and weeks go very quickly. Last week I went to Paris for two days with another Sister and enjoyed the change. Mrs. Depew thought we needed a break as the work at times is very hard, and the château being miles from a town, the monotony is apt to pall. Paris is much more animated than it was, more people and traffic about, and light at night. The barricades have been removed from outside the city and no search lights. On the return journey by car we were stopped four times by sentries for our passports. On arriving back at the château we heard that several wounded had been brought in the night before from a village three miles away—Bittencourt—which had been shelled. Three died that night, all were civilians, and one was discovered to be a woman when in the theatre. She was brought in with her husband, her two children were killed outright, her husband died in the theatre, and she, I am glad to say, died next morning."

"Yesterday I was wakened at 5 a.m. by the cannons. Is it true the Germans have retaken Soissons? We get very little news from the *Paris Daily Mail*."

Miss Windley is at Calais, Sister will know her, she left the château just after Xmas."

Ambulance Train,

From Miss Beardshaw, 29th January, 1915.

"We left Versailles in a large covered motor ambulance, sitting on top of our luggage, and so travelled to the station en route to Paris. Slept off and on through the night and arrived at Boulogne 5.30 a.m. Reported ourselves at an office and had tea from some Red Cross U. A. D's on the station. Saw a hospital ship in the harbour and asked to go over it. It turned out to be an Indian hospital (a Donaldson Canadian liner of Glasgow). It was about half full of wounded and sick natives. They looked very pathetic but responded to one's looks of sym-

pathy. I was surprised to find they wear their hair long under their turbans, done up in a rough top-not. The majority were middle aged men. The orderlies spoke English and were delighted to show us over their beautiful boat. It was spotless, and put our hospital to shame as regards cleanliness. It was just one glitter."

"Our train, No. 12, was at Rouen, we were told to join it next day. Spent our time seeing various hospitals and meeting Guy's people. We put up at an old hotel and were well waited upon by some little French girls. They told us that now the women and girls in Boulogne have to work very hard. The place is so full. The fish market going hard. Quantities of transport goods on the quay. It brought home to me the "bigness" of the war. I love that side of it, it is all so wonderful—the management of all details. We arrived at Rouen to hear our train was lost—it was three miles out of the town—so we eventually joined in the afternoon."

"It was nice to see Rouen again. The place was leading a much more normal life than when we saw it in August. Ours is known as the "Khaki Train"—a Kitchener's Train, it is half Gt. Eastern and half L N.W. There are 220 beds, stretcher ones, two layers. In between each carriage is a little department, a place for plates, mugs, dressings, etc. The officers' and sisters' part is at one end with their kitchen. Dispensary in the middle. Patients' kitchen and orderlies' quarters at the other end. There are three medical officers, one army sister in charge of wards A and B and the general run of all our work. I have C, D and E wards, and Miss Wilson has F, G, H, a "London" nurse has the three others. The army sister is an old Guy's, so I think we shall be very happy together. There are forty five orderlies. The paint of the train white, bed frames dark red, curtains green, and blankets dark brown, so the general effect is very pretty. It is kept most beautifully clean, and the orderlies are very proud of their train—the best on the line they say. We go up and down to the clearing station so I am greatly looking forward to seeing Sisters Kiddle and Ames, I do hope they will not be moved before we get there. We often take convalescent patients about, often to Havre. Have been between Havre and Rouen twice these last few days."

The Two Cities.

THE R.A.M.C. man in the corner pushed aside the blind and peered out into the darkness. The train, rocking and swaying, roared through a twilit station. "We must be somewhere near Redhill, I should think," he said, as the lights of a scattered hamlet stretched away into the distance. . . . "We're close on due, for all that." And five minutes later we crossed the gleaming band of silver, which was the Thames, and entered a dim and chilly Victoria. Our hamlet had been the London suburbs—Zeppelin proof.

The two Belgian ladies in the opposite corners of the compartment, who had been recovering from the effects of a bad crossing, sprung into activity and imperfect English. The R.A.M.C. man, leaning out, greeted a waiting friend; all the silence, the aloofness which a long train journey always produces, became full of raucous sound. Slowing down, we saw in the siding opposite a detachment of troops entraining, and to the usual bustle of arrival at a central station was added the din of soldiers shouting, singing, laughing, the clank of rifles laid down, occasionally a word of command.

It was a glimpse, a fleeting impression. The half-light, softened still more by a haze of yellow fog, the vivid note of the uniforms, the strident red of badges and facings, the flushed, sweating faces of the men rushing hither and thither in purposeful disorder, in the foreground a group of officers, immaculate, monocled, imperturbable, chatting as if war were a game of golf—it was a scene for Steinlen, the artist of the Apaches and the *bals des barrières* to render, or such as Verhaeren, who wrote "Les villes tentaculaires," would describe.

And as I lingered, dazzled for a moment by the rush of sound, another scene came across my mind, and I thought of the first real impression that the war had given me. The "Winter Garden" of a modern cosmopolitan hotel, rococo, harsh, banal, and seated there on gilded wicker chairs, two old peasants, a man and his wife, both in their best black, *endimanchés*. The man, ill at ease, fidgeting a little and giving quick, half-timid glances around him, like a frightened wild thing, fresh in captivity. She, more stolid, perhaps, or was it only set on hiding her grief from these hurrying callous folk who seemed to count so little that *he* was dead, looking straight in front, with reddened eyes, her spotless *coif* a little to one side, clasping her gamp firmly in both hands. And the black panier of provisions, half hidden under the folds of her ample gown, the panier that she had packed so carefully, full of the best that the little farm could offer, way down in Brittany, the butter and eggs, and the pears from the tree on the south wall that he had always loved so: all the things that were to have made him well and strong again, lay disregarded, almost forlorn.

Poor lad! His was a heroe's death, if simplicity and faith and courage count for anything. Joking sometimes, always smiling, even when the anguish took him, naïvely distressed to know the priest had not come to hear the story of his little venal sins, yet rejoicing that France had held him worthy to die for her. Begging us, too, even as the words faded on his lips, not to let his people, *mes vieux*, he called them, see what was left of his body, "*ce serait trop dur pour eux, vous savez.*" He may rest in peace, this brave, simple soul, buried as he will be in a pit with a hundred others, where later a deputy will make an oration beside a monument designed by an academician, for this grief at least was spared them. Later, perhaps, at Easter or la Toussaint, they will make a

pilgrimage to lay a bunch of withering country flowers on the grave in a Paris cemetery where he lies among the rest.

And London, how had she changed, during these months, when, as the papers say, her very existence was at stake? Darker, of course, a little subdued, fewer young men strolling about as if all eternity was theirs, a brave show of khaki. The music-halls, such theatres as have braved the cataclysm doing good business to crowded houses. On New Year's Eve three halls I tried were packed half an hour before the show commenced, and Frascati's and the Criterion were filled with the usual throng; they were in khaki, that was all. Trade apparently is booming, and all the available young men having joined or been coerced into the army by threats of dismissal, we are settling down to enjoy ourselves as well as our offensive climate and the restrictions placed by the government on rational enjoyment will allow until the war is over.

In Paris it is so different. There the nearness to the fighting, the fact that every home almost is involved makes anything like enjoyment impossible. The people are too dazed, too crushed, the war is so close to everyone; the soldiers from the front that one sees wandering about the streets muddy, tattered, unkempt, as a rule without a sou in their pockets, the daily trains of refugees waiting in sidings till they can be taken on to some far off destination, the women wild-eyed and haggard, the children plaintive and wondering, the daily spectacle of wounded being carried to and fro in ambulances, the motor 'buses and lorries charged with foodstuffs and munitions for the front, all the grim camp followers of a great war leave no room for forgetfulness.

On Christmas Eve I ventured into the great silent spaces of the Moulin Rouge, transformed into music-hall cinema. There was the usual performance, the performing dogs, the ventriloquist and his dummies, the soubrette, the woman in Alsatian costume singing one of Paul Deroulède's patriotic songs; but the effect in that garish empty hall, the few rows of people who had come there to forget and could find no forgetting, laughing with tired, mirthless faces, was such that I left feeling near tears. And just outside, torn and flapping in the wind there showed an ancient poster, "*L'orgie à Babylone*," it read, "*revue en deux actes et seize scènes; les plus jolies femmes du monde!*" Well, Well! "*Sunt lacrimæ rerum*," as Virgil says somewhere.

Meanwhile signs are not wanting—*vide* the *Times* on Christmas doings in the trenches—that the private soldiers on both sides will realise before long the extreme folly of blowing each other to pieces to vindicate the ambitions or justify the policy of their superiors, and, laying down their arms, will advise their officers to go and fight it out between themselves if it really interests them to do so. However, I suppose we are (in reality) far enough from such a millenium of commonsense. G. H. F. G.

London, January 11th.

A Case of Acute Oedema of the Lungs.

Mr. E. R—, a carpenter and joiner, aged 42, married, came to see me early in 1914, complaining of indigestion. The predominant symptoms were pain and a feeling of fulness in the epigastrium after food. He was of medium height, rather thin and extremely pale. He had severe pyorrhœa and well marked aortic regurgitation. On enquiry he said he did not know his heart was affected though he was sometimes a little short of breath. He gave no history of rheumatism or syphilis. I came to the conclusion that his dyspepsia was probably partly due to his pyorrhœa, and partly to his cardiac condition. After two or three attendances he declared himself much better.

On November 27th he again visited me; this time because of extreme shortness of breath on any exertion. He informed me that he had been examined in connection with some compensation claim, and had been told he had an aneurysm. On examination I found his heart was dilated in addition to the enlargement I had noticed on the first examination. Pulse rate 130. Dulness commenced an inch external to the left nipple in the sixth space and three quarters of an inch to the right of the sternum. It extended up on the right ride into the second interspace. No pulsation could be seen over this region, but a faint thrill could be felt. There was a harsh aortic "to and fro" bruit heard all over the præcordium traceable up into the neck. I could not convince myself that he had a definite aneurysm and later had him X-rayed, and the report was that no aneurysm could be seen. However, after several examinations I have come to the conclusion that he has had some dilatation of the first part of the aorta. His symptoms were, however, due to his failing compensation. I sent him to bed and saw him regularly, and under rest and digitalis he quickly improved. In five week's time he was getting up and taking a little exercise about the house, and later went for short walks. The last two weeks he has come to see me and appeared to be progressing steadily. His pulse rate was between 80 and 90, and his breathing quite easy.

On January 19th he came to see me in the morning and told me his breathing had not been so easy and that on two or three occasions, generally in the evening, he had had a feeling of tightness in the chest and difficulty in breathing, and had coughed up some frothy phlegm. One attack was very uncomfortable and had lasted some ten minutes or so. His pulse-rate was 100, and I told him he must go slower and take more rest. I put him back on to digitalis. He had previously been having a mixture of iron and arsenic.

At 12.30 a.m. on January 21st I received an urgent message to come and see him as he was very ill. While dressing I wondered whether his aneurysm(?) had burst or whether he had an attack of asthma. I put some

adrenalin in my bag as a precaution. On arrival I found him sitting on the edge of the bed suffering from the most extreme dyspnœa and spitting up large quantities of frothy fluid.

I learnt that the attack had commenced at 10.15 p.m. just after he had gone to bed. He thought that it had been brought on by drinking a glass of milk too quickly. He had had a short attack however earlier in the evening which lasted about fifteen minutes and had not felt comfortable since.

The breathing was thoracic in type, and there was marked sucking-in of the apices and intercostal spaces. The chest wall was not fixed in inspiration as in asthma, and he told me later that his difficulty was to get the breath in, not to expel it. His face was greyish, and his extremities became very blue and cold. The skin was quite dry. Bubbling râles and rhonchi were heard all over both lungs. The note was resonant all over but poor at the bases. The heart sounds could hardly be heard owing to the noisy respiration.

I sent for some oxygen and injected miii. of adrenalin hydrochloride with little effect. Ten minutes later I injected atropine gr. $\frac{1}{100}$. All this time he was spitting up the frothy fluid which threatened to choke him. It would have been impossible to have given him an emetic even if advisable, as he could not have taken anything by the mouth. I thought, however, if he could retch he would bring up the fluid easier, so I got him to put finger down his throat. He immediately brought up two or three ounces of fluid and was temporarily relieved so he voluntarily repeated the process later

He was becoming very exhausted and felt he couldn't last much longer. His pulse was now 160 and very feeble so I gave him strychnine gr. $\frac{1}{30}$. I wondered whether venesection would relieve him, but with no assistance there were difficulties in the way. At 1.30 I decided to try another dose of adrenalin, and injected mvii. The oxygen arrived at the same time so I turned it on. In fifteen minutes his pulse rate had dropped to 128, and his breathing was markedly better. I stopped the oxygen for five minutes and then continued it for another ten. By 2 o'clock the attack had subsided, having lasted three and a half hours, and I was able to leave him shortly after. The fluid was pinkish in colour with a layer of white froth like sea foam on top. Altogether he brought up nearly a pint.

Later in the morning I saw him again, and his breathing was quite quiet though he was very weak. Some scattered râles most marked over the left base were all that remained. His pulse rate was 100. I gave him morphia gr. $\frac{1}{4}$ and atropine gr. $\frac{1}{100}$, and he had five hours quiet sleep. In the afternoon his pulse rate was 88. The next day the signs in the lung had practically entirely disappeared. For the present I am giving him a mixture of Tr. Belladonna and Tr. Nucis Vom., but would be glad of any suggestions for warding off a recurrence of the attack.

W. S. GEORGE.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR :—As we now have wounded officers in Guy's I thought the following extract from a letter written in 1801, might interest your readers, as it shows that wounded officers were received at Guy's more than a century ago. The letter is published in "The Naval Miscellany" (vol. 1. p. 299.), edited by John Knox Laughton, M.A., R.N. Printed for the Navy Records Society, 1902 :—

From Lord Cathcart to Lady Cathcart,
Gloucester Place,
August 29th, 1801.

" . . . . From Lord St. Vincent we drove away to Guy's Hospital. Mr. Harrison, a man of large property, is treasurer to this institution, and is married to Pelly's sister, and resides in an adjoining building belonging to the hospital, and very spacious, in which Pelly is lodged, having been conveyed with other wonnded officers to London Bridge by water. He was well enough to see us and we found his sister reading to him. I never saw a patient so comfortably situated, and with his good temper and placid disposition, together with skilful and tender management, he has scarce any fever, and then had none, though the wound has already, at different times, discharged several large pieces of bone and a great piece of blue cloth, and there are more bones to come out. We learned there that the master is recovering very fast of his wounds, as is Maitland, whose wound is in the neck, but aggravated by rheumatism. William helped Captain Parker another way besides towing him, for he applied a handkerchief or bandage twisted with a stick to stop the blood. . . . ."

Lord Cathcart was the 10th Baron Cathcart in the peerage of Scotland and the first Earl Cathcart in the peerage of the United Kingdom. William was his eldest son. He was born on 30th June, 1782, he was at Eton 1791–5, and he entered the Navy in August 1795, as a volunteer on the Melpomene. At the time the above letter was written he was an Acting-Lieutenant in the Medusa. He died at Port Royal of yellow fever on 6th June, 1804. The wounded brought to Guy's received their wounds in the attack made by the English on the Boulogne flotilla on the night of the 15th–16th August, 1801. William Cathcart fought in this action but was not himself wounded ; Lord Nelson writing to Lord St. Vincent said "Young Cathcart behaved most exceedingly well ; he saved Parker from either being killed or a prisoner." Lieut. Charles Pelly's wound was "two balls through his shoulder blade and collar bone, which are both fractured ; " consequently a bad wound. Maitlands was only a flesh wound.

Believe me,
Yours faithfully,
W. HALE WHITE.

6th February, 1915.

"HAM" GOULD.

Appointments.

Civil.

George N. Meachen, M.D. Lond., has been appointed Medical Officer to Sherburn Hospital, near Durham.

Chas. J. Lamb, L.D.S. Edin., of Devonport, to be Dental Surgeon to Mount Edgcumbe Training Ship for Boys.

Naval.

To be Temporary Surgeon, R.N.: Surgeon Prob. L. S. Fry, R.N.V.R.

Royal Naval Volunteer Reserve: Surg. T. Turner to the *Pembroke*, additional for Chatham Hospital.

Military.

Dr. W. H. Brailey, of Hove, Major R.A.M.C. (T)., has been appointed Consulting Ophthalmic Surgeon to the General Hospitals for Indian Troops.

Supernumerary for service with the Officers' Training Corps: The undermentioned to be Lieutenant for service with the Medical Unit, University of London Contingent, Senior Division, Officers' Training Corps; J. H. Ryffel, M.B., B.C.

Guy's Hospital Maternity Charity.

Nurse for Externs' Side.

In February, 1913, the Board of Management of the Guy's Hospital Trained Nurses' Institution arranged to support a nurse for the benefit of mothers who had been attended in childbirth by the Students working in the Hospital Maternity District.

The nurse at no time to act as midwife or be present at time of birth. Her services to be called in only when there were nursing complications requiring more assiduous attention than could be afforded by the externs or unskilled helpers.

Arrangements were made for the nurse to reside at the Home of the St. Olave's District Nursing Association, Cherry Garden Street. A telephone has been installed and cases can be referred to the nurse by 'phone or in writing by the Charity, and in the same manner through the Out-Patient Visitors' Office.

The following short report of three months' work from the Out-Patient Visitors' Office will show that the scheme is in good working order and of great benefit.

Nurse Pitman began work on the District at the beginning of September and during the three months September, October, and November, 95 cases were referred to her:—

By the "Charity"	50
Out-Patient Visitor	28
District Coach	15
Telephone—source unknown ...	2
	95
Number of visits recorded as having been paid, being an average of 8·2 visits a day including Sundays	751

In 41 cases experienced nursing was required, including douches, attention to the breasts, removal of stitches, temperature charts, etc. One case was visited 52 times. Six cases are reported as having been assisted with clothes by the St. Olave's Charity and three with invalid dinners. In three cases twins were born and special nursing and attention was required. In twenty-one cases the baby was still-born or died within the first five days, and nurse attended the mother.

The cases referred by the Out-Patient Visitor are chiefly young mothers who apply for cards and appear to have no one to advise them. Good work has been done in visiting these, urging attendance in the Obstetric Department of "Out-Patients" when necessary and giving instruction as to what preparation is required. These women are only visited when the Nurse's whole time is not taken up by cases requiring special attention.

Nurse Pitman seems to get on well with the patients and so understand them. Her services are much sought after, and the number of visits she has paid testify to the large amount of work that has been done.

E. BEARDOE-GRUNDY.

Change of Address.

Lieutenant B. R. Parmiter, R.A.M.C., from the Infirmary, Lewisham, to Connaught Hospital, Aldershot.

The College, Guy's Hospital. Telephone number changed from City 8048 to Hop 5301.

(The Editor will be very glad to receive a post card with notes of any change of address.)

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Letters from Guy's Men on Active Service.

The Desert,
German S.W. Africa,
December 27th, 1914.

Dear Tanner,

I have just received a copy of the Gazette, a treasure received with indescribable feelings of reverence and joy. Perhaps you, on the other hand, may be interested to hear of those Guyites who are trying to do something in other parts of the world, those unfortunates who are not fighting on the Continent, but who are side-issued into little gnat-like campaigns. But I suppose even our show has its significance, and when one takes into consideration what a very practical training this is for those who hope to be landed on the Continent when the opportunity presents itself, one is more satisfied. Of this, one may be assured—as soon as this local affair is settled there will be a merry body of strong well trained men ready to add its gentle shove against the Kaiser's push.

I am scrawling these lines on the ground whilst a pitiless sand storm is sweeping over this desert. We are used to it having been here three months. A finer first line of defence than the 80 miles of desert the Germans could not very well possess. It is difficult to give you an adequate impression of the feelings arroused in one with eyes, nose and ears full of sand, and a water ration for drinking, cooking and washing of three-quarter gals. per man per diem. I wonder if you can guess how we get even this limited quantity, with no river, no well, no bore-hole water that one can drink. We are many miles away from the Sea Coast. It never rains. The temperature recently was 117·5° in the tents. The Censor may not like my telling you how. I wonder what an egg or orange looks like!

Yet we are most extraordinarily happy. My post is more or less a sinecure as everyone is so fit. We have had several scraps but no big encounter with the enemy. He sometimes plays about with aeroplanes and drops things from it. I was really perturbed when he dropped a shell twelve yards from where I was lying, all the stuff passing clean over me. I lay flat on the ground without cover of any sort, and I was quite certain my number was up. Rotten sensation altogether, and the transit of the shell makes a horrible sound.

As regards medical work—well, I think it depends on one's own enterprise. I look after a battalion 1,000 strong. All the officers and men are now sanitation mad and consequently epidemic disease does not occur. Serious cases are few—apart from wounds. Dental cases are exceedingly troublesome as one needs good teeth for the tack we get. I often wonder if the way I pull teeth out is quite correct. However, practice teaches, and even decayed stumps find their way out. Whenever conditions are favourable I do a few minor operations. Everybody was inoculated some time ago—two injections at intervals of, 10 days. So far no case of typhoid fever has occurred among the expeditionary force in G. S. W. A. As a precautionary measure I chlorinate all drinking water, when boiling it is not feasible.

As regards the actual results of bullets, shells, and so on, my experience is too limited to give you much of an account. But things are extraordinarily difficult at times. I have had my saddle bags fixed up for surgical emergency work. You can readily understand that the simplest way to treat wounded men often miles away and scattered all over the place is on horseback.

There is a wonderful difference between work in the Front Surgery and treating a man lying wounded in the veldt with nothing near except sand, heat and wind. Not long ago I came across a poor fellow shot through the abdomen at very close quarters. He was about six feet two, and with s chest like an ox. All his intestines were extruded and inflated, the liver was lacerated, and, of course, there was considerable hæmorrhage. He was perfectly conscious, and it took a huge dose of morphia and chloroform to ease him. A hot sandy wind covered all the dressings up as soon as they were taken out. Somebody was helping me, and when I did what I could I glanced up to find an old friend whom I hadn't seen for seven years, and who had been assisting me for about half-an-hour. It was a grim meeting.

Well, old chap, the stimulating effect of the Gazette has been overcome by the effects of the heat, and I think I'll conclude it.—Yours ever, A. S. LIEBSON.

P.S.—Have met May Adams, Saner's brother, Snow and other Guy's men here. Mullins is at t'other end.

Letter from an R.A.M.C. Orderly to his former colleagues in the Works Department:—

Boulogne-sur-Mer,
January 17th, 1915.
Roll on 1920.

Dear Davis & Co.,

Just a line hoping you are all well and "pushing the plumb." We are "casting lead" out here." "Now, that's enough," I know you say, "it's rotten." Well, I have not got much to say, for there isn't much to say. Things are very quiet on our side, and likely to be, I expect, until the weather changes. We keep running up and down between Boulogne, which is our base, to Lillers, Bethune, Choques, Merville, and the cases are mostly sick, rheumatism, bronchitis, frost-bite, defective sight, defective teeth, and various other ailments, with one or two wounded thrown in, etc., etc. I have also had one or two cases of venereal disease. I had two last journey, and one lad I asked what he complained of he said, "Under age and sore feet.' Asked how old he was, he said 16 years. I have to render a report of all cases in my three coaches, which hold 18 stretcher cases and 72 sitting up—90 patients in

my three coaches and two orderlies to a coach. We are living well, of course, considering the circumstances, and many probably better than they did at home. Bread, butter, cheese, jam and marmalade are issued to the patients, then the old renowned stew with fresh vegetables, very often roast beef, potatoes and green peas. We have a range on the train, so it does not matter whether we are travelling at 60 miles an hour or standing still, the "grub" is there, and then there is fresh bacon for breakfast every morning. I mention "fresh," because in Africa the only bacon we had was tinned, already cooked, and nothing but fat. We used to use it for frying purposes, so you see things are pretty comfortable that far. Tobacco (2 oz. tins) is issued free every week—W. D. & H. O. Wills' medium navy cut. Champagne, stout, brandy, roast chicken in tins, and other comforts for patients are also on the train, should it be ordered by medical officer. The weather is very bad —nothing but rain for weeks—and parts of the country are inundated; it's a job to tell whether it's a river or flood. How about the "POOR FARMERS NOW." Well, it's Sunday, by my watch 12.30 p.m. My little Mary s ays it's dinner time, which will not be long now, and we are at St. Omer, on the station siding. Arrived here last night, 9 p.m., from Boulogne, leaving there at 5 p.m. on Saturday evening. Shall probably go on to Merville, and load up, and back to Boulogne ready for another trip, and so on, etc., etc. Something is surely going to happen—the sun is shining, but rather chilly. Now I must leave you, and I hope this will find you at your best. "Tray Bon"—very good.

Best wishes and thoughts of you all. No doubt this will amuse you at 3 p.m., with the old urn to wash it down,

Yours sincerely,
W. D. MORRIS.
"*Train Sanitaire Quatre.*"

Guy's Hospital Missionary Society.

A meeting was held in January for the election of officers, etc. Nurse Combe (Sister Lazarus) was elected Secretary. The annual subscriptions was fixed at one shilling. Anyone connected with the Hospital is eligible for membership, and it is hoped that those who are not already members will send in their names to Sister Lazarus. The next monthly meeting will be held in the Nurses' Home on Thursday, February 11th, at 8.15 p.m., when Canod Beaulands of the S.P. G. will speak.

On Ash Wednesday, February 17th, at 8.15 p.m., the Bishop of Southwark (Chaplain of the Hospital), will preach in the Chapel. There will be a service on the Thursdays in Lent (except February 18th), at 8.15 p.m., when the preacher will be the Rev. A. L. Preston, of S. James, Bethnal Green.

Trench Foot or so-called Frost-Bite.

THE following is a summary of the replies made to the letter concerning Frost-bites sent to each of the hospitals. It constitutes a collection of facts which is published as a preliminary or interim report. As will be observed, it is by no means complete, and it is hoped that some of the gaps which at present exist in our knowledge of the cause, treatment and prevention of the disease may shortly be supplied. It is well nigh impossible to criticise or pass any comments upon the statements set out below owing to the present insufficiency of experience and knowledge. For purposes of convenience the subject will be discussed under the following headings :—

1. Nomenclature and cause.
2. Number of cases treated and degree of severity.
3. Signs and symptoms.
4. Treatment and results.
5. Prevention.

NOMENCLATURE AND CAUSE.

(1) The first point which has impressed everyone is how very few of the cases have been actually due to the frost, and it would appear probable that only those few cases of dry gangrene which have occurred have actually been true frost-bite. In nearly every instance the name "frost-bite" is undoubtedly a misnomer since the factors which seem to cause the condition are long continued constriction of the limb and foot in tight putties and tight boots, combined with exposure to cold water and mud. Lack of exercise may also play a small part in its causation. In favour of the compression theory may be adduced the fact that many cases of œdema following the prolonged use of putties have come under our notice, but this appears to be insufficient to produce the above condition without the accompaniment of cold and saturation. There is no doubt but that the signs and symptoms exhibited are not only circulatory in origin, resulting from a vaso-constriction of the vessels, but are also due to peripheral neuritis. The length of time which is necessary to produce the disease varies as would be expected in different individuals, and no hard and fast rule can be laid down. On one occasion a rifle brigade, after marching 15 miles, went at once into the trenches and within 48 hours over 400 were incapacitated through the foot trouble described in this report.

180 men of the Cameron Highlanders were in the trenches without being relieved for eight days and only three suffered from slight frost-bite. None of them wore anything upon their legs and feet except boots which may explain the sparcity of cases.

(2) Reports have been received concerning 290 cases of which 24 were considered severe and 266 were grouped under the heading mild.

SIGNS AND SYMPTOMS.

(3) In ordinary uncomplicated cases there appear to be no general signs and symptoms present. At the most there may be a slight rise of temperature. Locally the toes and feet may show slight anæsthesia and œdema. The sense of touch heat and cold may be entirely lost and this anæsthesia will persist for some time after the toes have apparently recovered, and is only displayed by the man's inability to stand upon his toes. The toes feel cold to the touch but not to the patient, and if the hand is drawn down the dorsum of the foot an appreciable difference of temperature can be felt when the toes are reached. The next grade in severity will show discoloration and lividity or redness of the skin. There are brownish patches at the tips of the toes and on the extensor and plantar surfaces. Pain is present but mild for the first few days in the majority of cases, and is always worse when sensation and circulation are returning. This symptom is also most troublesome at night and often prevents sleep. In a great number of patients the most important and indeed the only symptom present is the pain which is of an aching, tingling or throbbing nature, and this may be out of all proportion to the signs observed and may persist for a long time in a manner comparable with that of intercostal neuralgia after herpes. The amount of voluntary movement of the affected parts is variable but passive movements are always painful. Patients frequently complain of inability to walk a long distance after an attack.

In severe cases the toes are jet black, hard and completely anæsthetic to painful stimuli. The feet may be swollen and red with numerous bullae or foul smelling with a septic discharge from the spaces between the toes. The oedema and redness may extend to the knees. Many men stated that after the removal of their boots the feet quickly swelled and became discoloured and this was followed by blisters on the points of pressure. In only a few cases were superficial ulcerations and numbness of the hands observed but this is compatible with the causes given above as opposed to the ordinary cases of frostbite.

It is interesting to note in view of the circulatory theory of causation that the dorsalis pedis artery could be felt beating quite near the toes in a great number of cases. Even when the foot from its appearance would seem to have completely recovered, pain will persist for some weeks in consequence of the peripheral neuritis.

The approximate time for the duration of the disease has not been given owing to the fact that pain with or without movement may follow, but when this complication does not occur the majority of mild cases were cured after a fortnight while the more severe cases, not counting those requiring amputation, were considered to take at least two months to recover completely.

In the severe cases when the feet are extremely septic the glands in the groin were found enlarged and septicaemia has been known to follow. One contributor quotes a case in which tetanus supervened with a fatal result.

TREATMENT AND RESULTS.

(4). The forms of treatment adopted fall into the following groups:—(a) General and (b) Local (dry dressings, powders, ointments, moist dressings, baths, massage electricity, and, for the most severe cases, surgical treatment).

(a) *General.* The usual anodynes have been administered internally for the control of pain, thus some of the Medical Officers use aspirin, antipyrin, potassium bromide, and salicylate, while others have resorted to opium and injections of morphia. Calcium lactate in view of its reputed value for chilblains has also been tried.

(b) *Local.* A great number of Medical Officers are of opinion that as good results as any follow masterful inactivity consisting of complete rest in bed with the feet raised and placed beneath a cradle together with the local application of cotton wool. One favourite method is to keep the skin absolutely dry and apply boracic powder or powder of bismuth fornic iodide, which does not cake, is said to allay pain, and to promote healing. Other powders are iodoform powder or zinc oxide, boric acid, and starch powder. Gauze may be placed between the toes, and the whole covered with cotton wool and a loose bandage.

The following paints have also been tried when the skin is unbroken :—Glycerine and belladonna, methylated iodine, chloroform and aconite liniment, oil of turpentine, turpentine and olive oil in equal parts (turpentine in some people gives rise to blistering of the skin), tinct. cantharides one drachm to liniment saponis one ounce, pigmentum chloral co., Friars balsam, and picric acid.

A lotion composed of the following ingredients has been tried :—R/. Lotio Plumbi cum opio. Lotio Acidi Carbolici 5 per cent. Methylated Spirits.

Another form of treatment consists in applying fomentations or antiphlogistine. Tepid mustard baths containing a tablespoonful to a gallon, given in the evening tend to relieve the pain at night. In every case where pain and tenderness will permit, massage should be instituted. The results obtained from electrical baths appear to differ. The forms of electricity used are the ordinary galvanic bath, leaving the feet in from half to three-quarters of an hour with a just perceptible current, ionization, and the sinusoidal current. Radium heat baths have also been tried. Where prolonged heat is required thermogen will be found better than ordinary wool, and antiphlogistine preferable to fomentations, but it is to be noted that the pain is sometimes worse when warmth is applied—for example, at night—being probably due to dilatation of the vessels already damaged by vaso-constriction. This may account for the fact that turpentine sometimes gives rise to pain. Some Medical Officers appear to think that in mild cases the rate of

progress is not governed by any particular form of treatment; but, as a general rule, it will be found advisable to try counter-irritants for mild cases and soothing application for the more severe.

Severe cases with a septic discharge should be treated in the ordinary manner first, thoroughly cleansing and swabbing the parts with an antiseptic solution, followed by fomentations or antiseptic powders. Gangrenous toes should be left as long as possible, for a much larger surface appears to be attacked when first seen than remains when the line of demarcation is defined.

Briefly, to recapitulate the treatment :—

1. *Rest in bed with the feet beneath a cradle.*

2. Apply cotton wool and either dusting powder or one of the paints suggested above.

3. Hot applications or electrical baths should only be continued if found beneficial.

4. If the surface of the skin is broken, cleanse in an antiseptic manner.

5. Massage should be instituted as early as possible.

6. *Surgical treatment should not be hurriedly resorted to.*

The only tests which can be performed in order to ascertain whether the man is fit are :—

1. To observe if circulation has been restored, as is shown by the temperature of the toes.

2. To see if sensation and muscular power are normal, as exhibited by the man's power of standing on his toes (being, in reality, a modified Romberg's test).

PREVENTION.

(5). The boots should be large enough to permit of *two pairs of socks being worn comfortably.* The outside of the boots should be well oiled or smeared with grease or dubbin. Most contributors are in favour of fishing waders being supplied to the men, or indiarubber boots preferably lined with something warm. There is no doubt that too much attention has been given to the provision of skin waistcoats and too little to the protection of the feet. The increased expenditure in long boots would be amply justified by the improvement in the feet of the man and the diminution in the number of cases of rheumatism, colds, and influenza. Some recommend painting the feet with iodine or picric acid; others suggest a greasy preparation such as lard, tallow, or vaseline. The soldiers rub their boots with mineral jelly, which is, in reality, a form of vaseline. One contributor recommends the following preparation to be rubbed on the feet and legs whenever possible :— Salicylic acid, 2 per cent.; iodine, 1 per cent.; vaseline, 97 per cent.

The socks should be covered with lard or tallow, and one suggests dry mustard in order to stimulate the blood to circulate, but this might lead to blistering. Boots should, of course, be dried whenever possible before wearing. The prolonged use of putties is certainly inadvisable, and in any case they should not be worn too tight.

Men should be warned to notify their officers the moment they feel anything wrong with their feet.

A question which yet remains to be settled is whether the sending of men back before all pain has subsided does not expose limbs which are susceptible and more liable to a second attack. As yet, in this country, we have no experience to guide us. It is advisable in the mildest cases to keep the man from duty at least three or four weeks and in the severer cases six to eight.

To sum up the above points with regard to prevention, the following rules will be found useful, if military exigencies will permit :—

1. The men's boots must be large, easy fitting, and watertight, for preference waders or indiarubber boots should be worn whilst in the trenches.

2. The feet, socks, and boots should be covered with grease of the heaviest nature possible.

3. The putties must not be worn too tight.

4. Men should not, if possible, be put into trenches directly after marching a distance, nor is it advisable for them to remain in the trenches any great length of time. Men who have complained of damaged feet should be conveyed by a transport rather than be allowed to walk.

5. Men should be instructed to report to the officers the moment they experience any trouble with their feet, and should be made to realise that the cessation of pain and feeling of coldness due to numbness does not mean that the trouble has been removed.

6. Men should be ordered to remove their boots and putties whenever possible in order to dry them and at the same time attend to the toilet of the feet. It will be found useful to carry an extra dry pair of socks in their valise.

7. The ration of rum should be carefully regulated so that it is given when men leave the trenches and not previously.

The information collected above, with the sanction of Colonel Peterkin, D.D.M.S., London District, is circulated by the Officer-in-Charge, Queen Alexandra Military Hospital, Millbank, as it was thought it would be probably of interest, containing as it does the views of the various hospitals.

Any comments or observations arising on this subject will be gratefully received by Lieut.-Colonel A. S. Woodwark, R.A.M.C., Queen Alexandra Military Hospital, who is in charge of this section.

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(To be continued.)

Pass List.

University of Oxford.

The following medical degrees were conferred on January 21st:—

B.M., B.Ch.—C. H. L. Harper, Wadham.

University of London.

D.Sc. EXAMINATION FOR INTERNAL STUDENTS.
January 27th, 1915.

Physiological Chemistry.—E. L. Kennaway,

Royal College of Surgeons.

LICENCE IN DENTAL SURGERY.

FIRST PROFESSIONAL EXAMINATION.—January, 1915.

Mechanical Dentistry and Dental Metallurgy.

A. S. Blacklaws.	†D. E. Robinson.
†W. Ashley Cooper.	F. R. Salsbury.
G. H. Danks.	H. M. Smith.
B. Eady.	P. A. Tucker.
C. R. Martin.	L. G. Whelpton.

† Dental Metallurgy only.

PRELIMINARY SCIENCE EXAMINATION, L.D.S.

Chemistry and Physics.

L Rabinowitz.	D. W. S. Adams.
*S. Godsill.	C. Glassington.
A. Weinberg.	R. S. Roche.

* Physics only.

CONJOINT EXAMINATION.—FINAL EXAMINATION.

Medicine.

*G. L. Attwater.	M. Chadwick.
*L. Horsley.	B. Mitra.
*S. Wilson.	E. C. Peers.
D. O. Richards.	*R. Sells.

C. C. G. Gibson.

Medicine and Surgery.

*R. B. Campion.	*N. H. W. Saw.
*S. W. Coffin.	*H. G. Dresing.
*A. F. Rook.	*E. J. Cooke.

Medicine and Midwifery.

*H. Parry Price.	K. J. F. Westman.

W. A. Easton.

Surgery.

G. R. Gokharkar.	*H. L. P. Peregrine.
*C. M. Anthony.	*C. G. McClymont.
*R. C. Matson.	*L. S. Fry.
*G. A. Pratt.	W. L. Partridge.
D. R. Jones.	*A. J. K. Drew.

Surgery and Midwifery.

*B. Sampson.	*F. E. R. Laborda.

Midwifery.

J. F. Mackenzie.	C. W. W. Baxter.
W. E. Williams.	G. D. Gripper.
J. E. Clark.	A. L. Punch.
G. S. Long.	M. J. T. Wallis,

C. H. Edwards.

Medicine, Surgery and Midwifery.

*O. G. Parry Jones.	*W. L. E. Reynolds.

*C. P. Symonds.

*Denotes completion of examination.

Birth.

MILLS.—On the 30th January, at 10, Cavendish Mansions, Langham Street, Portland Place, W,, to Queenie, the wife of Claude H. Mills, Surgeon, of 7, Cavendish Place, Cavendish Square, W., a son.

Marriages.

ROBINSON—WINCH.—On January 30th, 1915, at Christ Church, Herne Bay, by the Rev. C. Stocks, M.A., William Beresford Robinson, M.B., B.S., eldest son of Mr. and Mrs. William Robinson, of Riccarton, Christchurch, New Zealand, to Hilda Margaret, only daughter of Mr. and Mrs. H. M. Winch, Holmsfield, Herne Bay, Kent.

BERNHARD—UPSON.—At Edinburgh, on January 23rd, Philip Eric, youngest son of C. P. Bernhard, of Kimberley, South Africa, to Evelyn Mona, younger daughter of the late Walter John Upson and of Mrs. Upson, of Streatham, London.

PARRY-PRICE—BEVAN.—At St. Marylebone Church, W., on January 18th, Surg. H. Parry-Price, R.N., son of Dr. Parry-Price, of Reading, to Elsie Bevan, younger daughter of Mr. and Mrs. Bevan, Horton, Glamorganshire.

Deaths.

BARRETT.—On January 21st, at 6, Darnley Road, Holland Park, W., Dr. Alfred E. Barrett, M.R.C.S., L.S.A., of the above address and Grimston, Norfolk, aged 77 years.

WITCOMB.—On January 17th, Richard Stanley Witcomb, L,D.S. Eng., of 171, Richmond Park Road, Bournemouth, aged 37.

W. E. T.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE last dispatch from Sir John French must have been read with special interest and pleasure by all connected with Guy's, because it contained a permanent recognition of what our sons and daughters are doing to maintain the splendid traditions of the Medical, Dental and Nursing Schools of the Hospital.

Major Charles Robert Evans entered Guy's in 1891, and qualified M.R.C.S., L.R.C.P. in 1897.

Major Vincent James Crawford entered in 1893, and qualified M.R.C.S., L.R.C.P. in 1899, entering the R.A.M.C. in the same year.

We hope to publish further details of the careers of these gallant officers in a future issue.

Captain Sidney Clement Bowle, R.A.M.C., entered Guy's as a medical and dental student in October, 1898, having received his early education at Salisbury School. He qualified L.D.S. England in 1900, and passed the Final Conjoint in 1903. He was Dental House Surgeon from January to June, 1901, and Ophthalmic House-Surgeon from February to July, 1904. He entered the R.A.M.C. in February, 1904. We congratulate him—a member of both the Medical and Dental Schools—on his great achievement.

Lieutenant Ernest Harrison Griffin, B.A., St. Peter's College, Cambridge, qualified in 1902.

The nursing profession is well represented; four nursing sisters received mention in the dispatch—one from the Manchester Royal Infirmary, one from the Edinburgh Royal Infirmary, and, of special interest to Guy's, Miss Hannah Suart, acting matron at No. 8 General Hospital, Expeditionary Force.

Miss Suart was trained at Guy's, and since then has been in the Q.A.I.M.N. service. She spent three years in South Africa, and holds two South African war medals.

Miss Violet N. Kiddle was three years at the Belgrave Hospital for Children, and then commenced her training at Guy's, subsequently holding the post of Sister in the Out-Patient Department. At the time of volunteering for active service abroad, Miss Kiddle was Sister of the Clinical Wards. For some time Miss Kiddle was stationed at Versailles, and lately has been appointed to a Clearing Hospital.

Those of us who were fortunate enough to be in Clinical with Miss Kiddle know that Sir John French could not have chosen a more appropriate person for so great a distinction in recognition of ability and self-sacrifice.

Lieutenant-Colonel M. D. Graham, one of our wounded officers who has won the admiration of us all by his fortitude through a very serious illness caused by shell wounds, has been made a Commander of the Bath.

His record of service dates from 1885, when he received his first commission as Lieutenant in the Northamptonshire Regiment, and joined the Second Battalion then in South Africa with the Bechuanaland Field Force. On the termination of the Expedition he proceeded to China and later, Singapore.

In 1890 appointed Staff Officer of the Mashonaland (Rhodesian) Expeditionary Force, and after occupation of the Territory was appointed Chief Commissioner of the British South Africa Company's Police. This force saw much service in 1892–93 in connection with Matabele wars and rebellions. Promoted Captain November, 1893. Served in India in 1894–95, in latter year being appointed Staff Officer of Reserve Brigade, Chitral Relief Force. During 1897–98 attached to Colonial Office; thence on Staff in India 1899–1902, which included Embarkation Staff duties in connection with Indian Expedition to China. From 1903–1907 on the Staff of Royal Military College, Sandhurst, being promoted Major in the Duke of Cornwall's Light Infantry in 1906.

After serving with the 2nd D.C.L.I. in Bermuda, 1908–09, proceeded to South Africa with that Battalion, and from 1910–12 on Staff of Field Marshal Lord Methuen, Commander-in-Chief, South Africa.

In September, 1912, promoted Lieut-Colonel to command 1st Battalion Royal Berkshire Regiment.

In August, 1914, proceeded with the 6th Brigade, Aldershot Expeditionary Force to France.

The 1st Royal Berkshire Regiment took part in the advance on Mons, and the severe fighting in the vicinity of Mons on the 23rd August. Present at the rear-guard action at Villers Coterets on 1st September. And in the subsequent advance of the Allies, was present at the Battle of the River Marne on the 9th September, Hautevaines 10th September, passage of the River Aisne on the 14th September.

During the following five weeks the battalion occupied trenches in the Braye Valley, north of the River Aisne. Thence proceeding by rail to the Belgian Frontier. During latter half of October and first week November, very severe fighting N.E. of Ypres. Wounded 3rd November, 1914.

AT the outbreak of the War a few people collected a sum of nearly £25,000 with which to equip and maintain a Hospital for Wounded Sailors. The largest contributor was the Commercial Union Insurance Company, which, out of Sir William Dunn's bequest, gave £5,000. This is the same Insurance Company that has on more than one occasion been generous to Guy's Hospital. The other two largest contributors were the Duke of Bedford, who gave £2,000, and the Duke of Portland, who gave £1,000.

A committee was at once formed, Dr. W. Hale White being chairman, and the Palace Hotel, Southend-on-Sea was acquired (for what seemed to the Committee a satisfactory sum), for them to use it as a Hospital for the duration of the War.

Her Majesty the Queen was acquainted with what had been done, and at once graciously accepted the office of President of the Hospital, and allowed it to be called Queen Mary's Royal Naval Hospital. Ever since its inception she has shown the greatest interest in it, and one of the members of the Committee is her special representative.

The Hospital contains 270 beds, and the first patients were about 100 Belgians received in October. It was soon found that happily there were very few wounded sailors in this war, and the War Office asked whether they might send wounded soldiers; and after the first contingent of Belgians, all the many hundreds of patients who have gone through Queen Mary's Royal Naval Hospital at Southend-on-Sea have been British Soldiers.

Guy's is well represented on the Committee, for, in addition to the Chairman, Sir Alfred Fripp and Mr. Jocelyn Swan are members of the Committee. Dr. R .A. Chisolm, an old Guy's man, is on the Staff, and also acts as Resident Medical Officer. Mr. Ormond and Mr. Mollison look after patients in their special departments. Dr. Iredell conducts the Radiographic Department, and the apparatus for this is kindly lent by Dr. Hertz. The Visiting Staff of the hospital are the eight members of the Staff of the Victoria Hospital at Southend-on-Sea, and they have been most loyal in doing everything they can to further the interests of the hospital.

The Matron, Miss Finnemore, is a well-known Guy's Sister who was out in the South African War, and Mrs . Wells, who was also a sister at Guy's, has been helping her considerably. About 20 of the Nursing Staff received their training at Guy's.

The hospital was inspected the other day on behalf of the War Office and the report was entirely satisfactory. It was especially noted that it was particularly well equipped. It has its own Operating Theatre, X-ray Department, and Massage Department.

The Hospital has purchased a Coolidge X-ray Tube and equipment at a cost of £35. Mr. Shenton tells us that the important advantages of this apparatus are that it is practically everlasting, any degree of penetration can be obtained, it is capable of continuous operation without change of characteristics, and there is no fluorescence of glass.

On Wednesday Mr. Shenton showed us a self-sterilising probe he has invented for detecting metallic foreign bodies. He gave us the following short description of his apparatus:—

Two fine wire electrodes are mounted in close proximity, but not in actual contact. A low-tension current is connected to these electrodes in such a manner that when the probe is in contact with the cut tissues a certain degree of electrolysis takes place, the degree of which can be controlled by the amount of current used.

The evolution of oxygen at the probe point effectually sterilizes it, and prevents surface germs being transmitted to the deeper portions of the wound. Upon the point of the probe coming in contact with any metallic foreign body an electrical shock is produced which either lights a lamp or gives an audible warning by means of a modern telegraphy buzzer.

In the ordinary telephone probe the signal click is only audible to one person, and takes place on contact and on breaking contact. This instrument gives a warning visible or audible to everyone, and the signal is continuous during the whole time of contact.

The New Bacteriological Laboratories are now open; Dr. Eyre took over his new quarters on February the 15th. The old laboratory is to be added to the Dental Department (for the use of Probationary Dressers) which is still rapidly growing, and the extensions necessary to keep pace with developing scope and usefulness seem to have no limits. Arrangements have been made to repair the defective floor in the Conservation Room. We hope to publish in a future issue an account of the history of the Bacteriological Department with a full description of the new laboratories, so we shall not dilate upon the excellent impression left in our mind after looking over them this week. We congratulate Mr. Basil Sampson on his appointment as Junior Assistant Bacteriologist.

The Governors have increased the salaries and wages of the Clerical and Works Departments of the Hospital. An allowance of two shillings a week has been given to the Staff of the Works Department and to other male and female small-salaried servants. This is a practical recognition, all the more satisfactory because it was unasked, of the valuable services these workers render to the hospital.

The London County Council have inaugurated an Ambulance Service for the removal of street accidents in London. The service is already in operation in certain areas in the west of London. Further stations are being provided as speedily as possible in other parts of London, and the Council hopes that at an early date the service will be in full operation throughout the county. The City of London has had an ambulance service for years past, and we are glad that the areas in the south-east of London will soon be similarly provided. The service has been placed under the control of the Chief Officer of the Fire Brigade.

The following amusing instructions were given to a girl proceeding from Guy's to a Convalescent Home:—"She may stand and she may lay, but she must not sit." We cannot diagnose the awful malady with which this patient was afflicted.

A Correspondent suggests that we should start a column on "Things we want to know." We have not the courage to print all his queries, but submit two of them to you:—"Who shoots the pigeons in the neighbourhood of the Superintendent's House, and if the culprit is thinking of manning an anti-aircraft gun on the roof?" "When the goldfish in the park fountain is to be transferred to a glass bowl in Victoria?"

Books, etc., Received.—The Hospital, The Medical Press and Circular, The Middlesex Hospital Journal, The New Zealand Medical Journal, The Nursing Times, The Polyclinic, The St. Mary's Hospital Gazette.

With an Indian Field Ambulance in Flanders.

CIRCUMSTANCES over which I have practically no control having tied me by the leg for a short space, I have thought that some account of one's experiences with an Indian Field Ambulance in Flanders may interest the readers of the GAZETTE.

The details of our progress till we reached the front would be wearisome; how we left India not knowing our destination; how Europe became possible at Aden, and probable at Port Tewfik (Suez), and certain at Alexandria; how we landed at Marseilles and found the inhabitants had eyes for none but the brown men; how we journeyed through the vine country to the plaudits of the crowd and cries of "*Vive les Hindus*" (for only later did they appreciate that there are also Mahommedans in India and vary their welcome accordingly to the more comprehensive "*Vive les Indiens*"); how we tarried in the city of Joan of Arc to equip for a winter campaign; and how, at the last, we really started for Flanders on October 17th.

Needless to say, we did not know our destination then, as, to the best of our belief, the British Expeditionary Force was still on the Aisne.

Our first trek with our own transport to the station from the camp was not without incident, as there were not enough A.S.C. drivers to go round, and the mild Hindu did not prove a success at driving Clydesdales, so, en route, two of our five I.M.S. officers handled the ribbons.

We entrained at midnight, and, as accommodation was scant, two of us slept in an ambulance waggon on an open truck, which was not uncomfortable, but the getting there and back somewhat exciting. Our toilet, too, on the tail of the waggon amused the natives, and, personally, when my towel was wet and dirty, I exchanged it for a fresh one with an amiable lady who lived in a cottage by the railway.

The journey occupied 48 hours. We passed through Versailles in the early morning, skirted Paris, got a glimpse of the Channel at Calais, and even thought we saw the cliffs of Dover. You may imagine with what pride we pointed out the Old Country to our Aryan brothers, and the thrill which we ourselves felt who had not been home for a number of years! We crawled to Boulogne, passing a wrecked Belgian Refugee train, and then on to our concentration area, passing train-loads of wounded hot from the trenches, and felt at last that we were really for it, and that the use of Indian troops in the fighting line in Europe was no longer an idle dream.

We only stopped two nights in billets, and could hear the distant boom of guns and saw aeroplanes at work, not merely manœuvring as we had seen before, and then we marched as a division towards the sounds of battle.

The hospitals march behind the ammunition column and before the heavy baggage train, but, in our experience, we got inextricably mixed up with the latter on the first day, making ourselves extremely unpopular in our efforts to shoot ahead, and at times holding up the whole convoy while our heaviest waggon was bogged at the side of the road.. We reached what we hoped was our destination at 8 p.m., but found we had four miles further to go, and when we got there we found that we were not catered for in the billeting arrangements, so had perforce to bed-down by the roadside, the men in a field and ourselves on the floor of an *estaminet*, after having pumped three wells dry in watering our horses; this at 2.30 a.m., and with orders to be up for the march again at 5.30. But we were not to have even three hours' sleep that night, for a mule kicked his way into the bar shortly after we had settled down and had to be driven out and secured.

Next morning we were all agog with excitement: the brigade to which we were attached was to be the first to go forward, and we had the unique experience of seeing Indian troops going from France into Belgium in English motor 'buses (advertisements and all) to fight the Germans! This on October 22nd. We ourselves followed on foot, and billeted that night in a large town, our men in a corset factory (the model room, at our request, being withheld from their inquisitive gaze), and the officers in a spacious *chateau* which had, only the week before, housed a German general.

Next morning we were off again at 6, the rest of the division moving S.E., out of the town, and our brigade N.E., and across the Belgian border.

On the road we learned that our Indians had already been engaged, and saw a couple of them wounded and in a Cavalry Field Ambulance.

We reached our destination at noon, which was a village 3 miles south of Yprés, and selected a farm-house on the main road in which to open our hospital.

Our men had marched 39 miles in 46 hours, which was no mean performance for the Army Bearer Corps, especially as they had only been served out with boots the day we entrained. Of course, they were footsore, and the good Belgian housewives ran out with water to wash their poor feet, and started to do so; but we insisted that the men were not accustomed to these ministrations from European women, and set them to perform the office for themselves, though none the less grateful for the kind thought which prompted our hostesses.

The day's work was not done, for there were casualties to collect, and, after a couple of hours' rest and refreshment, three of our waggons and bearers to match went out to get into touch with the regimental aid-posts, while the rest of us tried to adapt the farm-house to hospital conditions. This was not easy, as there was no accommodation available except three large barns. The house was crammed with refugees, and five of us had to sleep on the floor of the parlour. However, the barns were water-tight and there was no lack of straw, so, at least, we could make our patients more comfortable than they were before, and could give them the best of good milk. Our Indian regiments were interspersed among the Cavalry Corps, who were at this time in the trenches, and were spread over a three-mile front. Our own position was ideal for a hospital, being central and out of range of the enemy's guns. To protect ourselves from hostile aircraft, and incidentally house some of our personnel, we erected a few tents with giant red crosses sewn on them.

Presently the first batch of wounded came in —not more than a dozen—and more cheerful sufferers I have never seen, what with the honour of being the first to shed their blood on European soil for the "*Sirkar*," and the prospect of an heroic convalescence on "*Wiliyat*," they were full of joy, but at the same time they felt they had hardly had their money's worth, and professed a keen desire to come back again.

And so each day for a week a handful of wounded and a few sick were collected by us from the regiments, and in turn sent back by us after twenty-four hours, more or less, to clearing hospital by empty supply motor lorries, for at this date we had not a regular service of Red Cross motor ambulances working with us.

On the 29th we heard the most terrific fusilade going on all day and far into the night round Yprès, every variety of cannon, and musketry which sounded like a glorified "*feu-de-joie*"; and on the following day the German attack developed itself on our front.

Just previous to this, the half of our brigade marched to join the division further south, taking its medical complement, and leaving us with two sections of the Field Ambulance and three officers, including the C.O.

During the 30th and 31st the fighting was fast and furious, culminating in street and house-to-house fighting in Messines and Hollebeke. It afterwards transpired that a whole Bavarian Army Corps had thrown itself at our thin line of British Cavalry and Indian Infantry, and that they had an enormous artillery superiority; but the barbarous methods of bomb and sap had not yet been evolved, and our gallant men rendered more than a good account of themselves before being overwhelmed by superior numbers and eventually forced to withdraw.

The afternoon and night of the 30th brought us 82 casualties, including the first Indian V.C., and another fine Afridi who was wounded three times before he would stop fighting, and was straining to get back at them while I was dressing him. (I am glad to think that the King has also honoured him on the first of January.) On the 31st the Germans had sufficiently advanced their guns to endanger our hospital, and we received urgent orders to move back. Our waggons were out collecting more, and we had 80 wounded to evacuate, and no visible means of doing so! However, simultaneously with sending orders to us, a message was also sent to the Clearing Hospital and a fleet of Red Cross Motors and four-horse ambulances came up at the psychological moment and cleared us, and we got away half an hour before the German guns started dropping their cards in the neighbourhood of the farm.

En route we collided with the 7th Divisional Transport, which was temporarily moving into the country on account of the unhealthy crustacean atmosphere of Yprès; and when we had sorted ourselves we settled down in another farm-house even less suited to hospital requirements than the last. Here our waggons joined us, and brought a further 31 wounded, some of whom were desperately hit. The next day found us making a further strategic move to the rear, and, on this occasion, in the absence

of a clearing convoy, we had to carry our patients with us, making those walk who could, as three of our four waggons had again gone out to collect more. Here we halted for two days in a brewery and were able to give more adequate attention to our wounded; an abdominal case which we had carried and kept for three days was eventually evacuated, and one is glad to think that he is alive to tell the tale to-day.

The regiments collected their stragglers and counted the cost, which was heavy, but were consoled to think that they must have inflicted three or even four times the loss on the serried ranks of the enemy.

Our retirement was covered by fresh troops, including the London Scottish, who earned undying fame on that day at Messines, and presently the magnificent French "75's" came up and more than equalised the artillery position, putting the Bosches back in their proper place, which was where they were before.

After this, and the thanks of the Cavalry General under whose orders the regiment had been when the brigade was split in two, we recrossed the Belgian border and rejoined the division further down the line. We were given a few days' rest to refill our panniers and scrub down our gory stretchers, and re-opened again to receive casualties on November 11th; this time in a Roman Catholic Club, for we were now in a considerable town. The Division had been experiencing a pretty rough time, and our sister ambulances, which were more fortunately housed in schools, had been kept busy. The whole Division was taken out of the trenches for a rest on November 16th, and the following day we moved back into billets a few miles in rear of the fighting. Here we first began to get into touch with the other Indian Division, and when next we resumed the offensive it was as an Indian Army Corps. The middle days of November are memorable for bright and frosty weather; some of the nights were intensely cold. We heard heavy and distant firing in the direction of Ypres, and learned, in due course, that it punctuated the deathless story of the 7th Division and the shattering of the Prussian Guard. On 22nd November our division began to exhibit signs of restlessness again, and on the 23rd we were somewhat hurriedly ordered to move forward and open up at once to receive casualties. The fighting of this day, which continued into the early hours of the 24th, is graphically described in official despatches; how trenches lost on the previous day had to be recovered; how the Indian Divisions advanced twice by day across the snow only to be repulsed; and how eventually they succeeded in a third assault after night-fall. The casualties were heavy, especially in officers, but those of the enemy were heavier still, and we took over 100 prisoners, including three officers.

We had barely reached our appointed place, which was a small village school, when the wounded started coming in, and, early realising that our accommodation was inadequate, we had to expand into neighbouring houses. This night we received 90 wounded, and were able to evacuate all but three in the course of the next day to Clearing Hospital. The following night was heavier still, for, though the numbers were less, the cases were more severe, being the more seriously wounded of the night of the 23rd, and we were short of a medical officer, as one of ours had been sent forward to a regiment which had lost its doctor, a shell having burst in his aid post.

I noticed on this night several cases in which the application of the first field dressing had become dangerously tight through effusion, and many a limb was pulseless from a combination of this cause and frostbite, for the weather was still bitterly cold, and several of these men had lain out for a night and a day before removal to the regimental aid-posts. The next morning we cleared our hospital of 58 patients, including five German wounded, and moved forward to a more suitable site nearer to the firing line. Here we found an almost ideal place for a Field Ambulance, a beautiful and spacious *chateau* with electric light, which had served as a hospital to various Divisions during the past six weeks, and had a melancholy record of the fact in the graveyard in the grounds. The only drawback was the close proximity of a battery, which was inclined to draw the German shell fire.

The patients were accommodated in the *salons* on the ground-floor, and ourselves most comfortably housed in delightful rooms upstairs, while our personnel were in barns and coach-houses, and our transport was parked within the square of the building.

Wounded came in, in reasonable numbers, during the next few days, but the sick rate was rather high; the men's feet had suffered terribly during the frosty days in the trenches,

and it was at this time that we got our worst cases of frostbite; there was very little other sickness.

Though there was a lull in the fighting, there was no truce, and regimental medical officers put in some gallant work in rescuing wounded men who had been lying out between the trenches since the night of the 23rd—24th.

Two such Indians were brought in as late as the 29th. They had had their first field-dressings applied by a humane German (there are some), and though in a low condition from hunger and cold, they did well. Another—a Tommy in the Leicesters—had lain out for 48 hours after a wound in the right hock, but the poor chap had both his feet frost-bitten by the time he reached us, and we had not succeeded in restoring the circulation before he left for clearing hospital, so I fear he did badly.

Here we had some experience of treating British soldiers, and started a ward for Tommies, and I never wish to treat more grateful, big-hearted men. Our "Mercenary Army" is a wonderful production of the British Nation, and the private soldier is beyond all praise; he has enhanced his reputation before the World, and even the "contempt" of the Prussian has been short-lived.

I recall a laddie in the Black Watch who was brought in with both ankles badly shattered, and consequent collapse. I offered him brandy (*pace* Sir Victor Horsley), and asked him if he would like it hot or cold, to which he replied, "Ah, well; the water's just a matter of form"; so he had it neat! Another man in the same regiment was brought in with his kilt blown to ribbons by a bomb, himself escaping with only slight flesh wounds.

A lance-corporal told me how he and six others discovered a cellar in a deserted house near Festubert, and how, after getting elevated with wine, they set forth to stalk a German trench on their own; how they discovered 23 unexpectant Huns and scuppered the lot with the bayonet; and how they returned and reported progress to their company commander, who called them liars, till he himself had visited the trench; but I never had an opportunity of getting this yarn confirmed by the regiment concerned, so give it for what it is worth.

In due course the battery, up against the wall of our *chateau,* forced itself on the notice of the Germans, and one day a 90-pounder shell fell unpleasantly near our bearers when they were cooking, which scattered them hurriedly, but fortunately it was what is technically known as a "bad burst," and no damage was done; the major part of the shell adorned our mess table for the remainder of our stay.

We left the *chateau* on December 4th and retired into billets a day's march in rear of the area of activity for a week's rest. On the 10th December we returned to business, and this time "opened" in an *estaminet,* in which—and its annexes—we were able to arrange accommodation for about 80 patients.

By now, with the aid of Lord Hardinge's Fund and private charity, notably The Eastern League, we had been able to supplement our government equipment; we had mattresses, cases for the straw pallets, socks, and invalid clothes, Primus stoves, an acetylene surgery lamp, and last, but not least, a splendid portable boiler presented by Lord Curzon to each unit of the Indian Army in Flanders; this latter enabled us to let no patient pass through our hospital without, at least, a dish of hot tea. The work was desultory for the first few days, but on the 16th, we collected 65 wounded and a British officer from a single battalion which had carried a German trench near the La Bassée Canal. This little affair was by way of attracting the enemy's attention while the main assault was delivered by our French Allies, south of the Canal, and effected its purpose admirably.

On the 20th we were very busy again. Another ambulance was in our old *chateau* of a fortnight before; the place becoming unpleasantly hot, they evacuated all their patients (125) to us, and cleared; meanwhile our Bearer Division went forward, and, using the *chateau* as an Advanced Dressing Station, collected patients there temporarily from the Regimental Aid Posts and sent others direct through to us in the Tent Division.

During the thirty hours covering the 20th to the early hours of the 22nd we passed 325 casualties through our hospital, and this was largely due to the Red Cross Motor Ambulance Service—a very present help in time of trouble—who surpassed themselves on this occasion. Convoys would come up, often together, of full and empty cars, the one to drop their load and go back for more, and the other to carry off to Clearing Hospital men who had already been dealt with and made comfortable. The weather

conditions were appalling, and all the men who came out of the trenches were caked with wet mud up to their middles, and, in the case of the Gurkhas, up to their arm-pits; we expended 200 pairs of socks in one night.

We were short of a Medical Officer, as again, one of ours had been taken to replace a regimental casualty; two of our M.O.'s were forward with the bearers and waggons doing great work under less safe conditions than ourselves. But our Indian subordinate personnel played up well, the sub-assistant surgeons and ward orderlies (dressers) were kept busy with the dressings, the cooks were flying to and fro with hot teas and *chupattis,* and the pack-store havildars full of work issuing fresh clothes and stacking rifles and equipment. So, though some of our patients were only with us two hours, they all got food and dry clothes before moving on, and those who needed it had their dressings changed. We had some hopeless cases in these bad days: one was brought in dead, and four others died in our hospital. The most distressing case that I can recall was that of a man shot by a rifle through the outer rim of the bony orbit on the right side; the bullet gouged out his right eye, passed behind the nose, without apparently interfering with nasal bridge, and exploded the left globe in its exit; and he never looked like dying! After clearing our hospital we retired into billets on the 23rd, and enjoyed Christmas and the New Year well away from the trenches; and the Indian Corps—sadly battered and depleted—was given a well-earned rest until far into January.

The professional work in a field ambulance is, of necessity, limited, since it is a mobile unit and is not intended to provide the refinements of a hospital. Moreover, the advantages of rapidly removing all wounded and the seriously sick from the fighting area far outweigh any disadvantage resultant from the journey. Of course, dangerous cases, such as abdominal and chest wounds, are not so removed, unless there is the most urgent necessity, such as danger to the hospital buildings from shell fire, or the possibility of a retirement.

The surgery of a field ambulance is practically limited to rough amputations of shattered limbs, and control of arterial hæmorrhage by ligature in the wound; occasional ligature of a main artery, as in a case where I was unable to control the bleeding locally, in a through and through wound of the fore-arm, and had to tie the brachial in the upper arm. Trephining is rarely done for various reasons of time and expediency, but I remember a brilliantly successful case in a sister ambulance, in which a life was certainly saved.

No attempt was ever made, in our practice, to close wounds with sutures, and amputation flaps were only brought together by the application of dressings. The use of anti-tetanic serum in all cases of wounds—as a prophylactic—came in as a routine measure after we had been in the field a month or so. Morphia was given lavishly. I know of no contra-indication to the use of morphia for wounded *in a field ambulance,* and our sub-assistant surgeons had orders to give morphia to any man who complained of severe pain, or was unduly restless. The character of the wounds changed with the times; in Belgium we had a large majority of bullet wounds; at Neuve Chapelle shell wounds were more frequent; and at Festubert and Givenchy we became too familiar with the dirty work of the bomb.

It is a curious thing, but in close on a thousand wounded men, I cannot recall a single case of bayonet wound. Our patients frequently spoke of getting in with the bayonet; can it be that the bayonet wound is too deadly to reach us, or that the Hun is not so good with the bayonet as the Allies, or that our people were romancing? I do not know.

Of serious sickness we had surprisingly little—practically none before the weather broke in late November; and then it was mostly frost-bite and rheumatism, and the majority of these cases were subjective rather than objective in symptoms. After we had been in billets for a fortnight in the New Year, bronchitis became more prevalent, but still pneumonia was a rarity. Bowel complaints have been almost unknown, and for this we have to thank the magnificent arrangements of the Army Service and S. and T. Corps.

C. H. REINHOLD,
Capt., I.M.S.

15th Feb., 1915.

Pass List.

Royal College of Surgeons.

PRELIMINARY SCIENCE EXAMINATION, L.D.S.

Chemistry and Physics.

L. F. Fouraker.

Obituary.

NURSE CLARE HAWKINS.

WE regret to announce the death of Nurse Clare Hawkins, in Mary ward, on February 20th. The first part of the funeral service was held in the Chapel at 1.30 p.m. on February 23rd, and the burial took place at Norwood Cemetery.

Nurse Hawkins entered Guy's in July, 1911, and became head nurse in Esther ward. Owing to ill-health she was unable to complete her training, though she had seemed so very much better in November last it was hoped that she might soon resume work. At the end of December she became seriously ill, and again returned to Mary as a patient. She was a brave sufferer, and her smiling cheeriness, even when in pain, helped many colleagues through the day's work. To her father and mother, who had lately come from India, we express our deepest sympathy. L. V. H.

Appointments.

Civil.

University of London—At the last meeting of the Senate the title of Professor in the University of London was conferred upon Dr. T. M. Lowry, F.R.S., D.Sc.

The following additions were made to the Faculty of Medicine: T. J. Evans, M.A., R. A. Greeves, M.B., B.S., F.R.C.S.

C. E. Salter, M.D. Lond., F.R.C.S. Eng., has been appointed temporary Assistant Medical Officer of Health and Assistant School Medical Officer for Scarborough.

F. A. Sharpe, M.D. Lond., B.S., has been appointed Medical Officer of Health for Barnsley.

B. Wallis, M.B., B.C., has been appointed Medical Officer of Health for Helston, Cornwall.

Naval.

Temporary Surgeon W. E. Fox, to the *Laurentic*.

Royal Naval Volunteer Reserve: to be temporary Surgeon, Stanley Worthington.

Staff-Surgeon A. R. Brailey has been appointed to the *Victory*, for Haslar Hospital.

Royal Army Medical Corps.

Supernumerary Captain T. C. Lucas is restored to the Establishment (dated January 5th).

To be temporary Lieutenants: T. R. Trounce, H. W. Doll, D. M. MacManus, Stanislaus Reader, S. W. Coffin.

Eastern Mounted Brigade Field Ambulance: K. B. Clarke to be Lieutenant.

Territorial Force: A. E. Williams to be Captain, whose services will be available on mobilisation. Second Lieut. O. Parry-Jones, from General Reserve of Officers, to be Lieutenant (on probation).

Donald Clewer, L.D.S., R.C.S. (Eng.), has been appointed Dental Surgeon to the 22nd Division of H.M. Army, with headquarters Military Hospital, Seaford, with the rank of temporary Lieutenant.

Capt. E. P. Minett, R.A.M.C. (T)., 6th Field Ambulance, 2nd London Division (seconded), acting as Surgeon-Captain to the local forces of British Guiana.

To be Lieutenant, L. Price Harris, R.A.M.C., 4th London Field Ambulance, present headquarters Dorking.

To be temporary Lieutenant, R. C. Matson, transferred from the Artists' Rifles, dated February 12th, 1915.

Sanitary Division: Major F. E. Fremantle, R.A.M.C. (T.F.), to be temporary Lieutenant-Colonel.

Indian Medical Service.

Capt. F. J. Kolapore, I.M.S., is appointed to hold collateral charge of the Civil Surgeoncy of the Bhamo District, India.

The services of the undermentioned Officers of the Jail Department are placed temporarily at the disposal of His Excellency, the Commander-in-Chief in India, with effect from the dates on which they were relieved of their duties: Capt. F. A. Barker, I.M.S., Capt. P. K. Tarapore, I.M.S.

Lieut-Colonel S. E. Prall, M.B., B.S., I.M.S., has been allowed by His Majesty's Secretary of State for India to return to duty.

Mentioned in Sir John French's Dispatches.

Major C. R. Evans, R.A.M.C., Major V. J. Crawford, R.A.M.C., Capt. S. C. Bowle, R.A.M.C., Lieut. E. H. Griffin, R.A.M.C. (temporary).

Change of Address.

Temporary Lieutenant Donald Clewer, R.A.M.C., from 56, Font Hill Road, Hove, to Military Hospital, Surrey Home, Seaford, Sussex.

R. C. Matson, M.R.C.S., L.R.P.C., 53, Campden Hill Road, Kensington, W.

Lieut. J. L. Perceval, R.A.M.C., Hotel Redcliffe, Paignton, South Devon.

Capt. M. A. Rahman, I.M.S., c/o Messrs. Grindlay & Co., 54, Parliament Street, S.W.

(The Editor will be very glad to receive a post card with notes of any change of address.)

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Chronic Abscess of Bone, and its Treatment.

CLINICAL LECTURES

BY

MR. CHARTERS SYMONDS, M.S., F.R.C.S.,
Consulting Surgeon to the Hospital.

LECTURE I.

GENTLEMEN,—I want to express, in the first place, the great pleasure it gives me to come to-day to my old School and do a little substitute work for those who are engaged more nearly to the Front than we are. I quite realise that it is not because of any want of lecturing power in the School at the present moment, but rather that it was thought that perhaps a little variety might be interesting; and certainly it is very interesting to me.

I thought that to-day I would ask your attention to some cases which have interested me for a long time, and I shall be fortunate in being able to bring before you some of the patients themselves. The subject I want to speak to you about is chronic infective abscess of bone. If we look at the museum specimens, of which I have a few here, it is interesting to notice that only two varieties of abscess of bone are to be found. An abscess of bone is the result of chronic central osteitis, as differing from that on the surface of the bone—periostitis. And looking at the specimens—and I think we can go to Guy's for examples of every form of disease—we notice that there is no example of a septic central abscess of bone due to an ordinary infective process. Here is one of the best examples in the museum of tuberculous disease in the great trochanter, No. 4232. It is a very beautiful specimen, and shows a tuberculous deposit just at one side of the epiphysial line; it is on the trochanteric side, not on the cervical side, and it is probably in the epiphysis of the trochanter. It is lined by a definite membrane. The head and neck of the femur were excised by Mr. Howse many years ago, and so we obtained this specimen. There are several examples of tuberculous abscess of bone, and this is one of the best.

I call your attention to another to show how frequent these are. Here is another good example of central abscess of bone, which is labelled tuberculous, 4235. You see a large abscess in the lower end of the femur, lined by granulation tissue, and at the lower end of it you can see a sequestrum, plugged with tuberculous material—a common condition to be found in these abscesses. Then there is this one, 4234, also labelled tuberculous; you can see the cavity in the centre of the bone. I show you these rather to indicate what I mean by a central abscess, a tuberculous or other form of central osteitis, leading to the formation of a cavity in the bone. This particular one, 4237, I shall try and rescue from the tuberculous series, and place it among the variety of acute central osteitis. There is no membrane here which can be microscoped and, therefore, proved to be tuberculous, and, on the whole, it so resembles the cases I want to deal with to-day that I hope specimen 4327 may be rescued and may belong to my class which I am bringing before you. In this little specimen, 4299, you find an obvious cavity in the lower end of the tibia, and it is labelled as due to congenital syphilis. It is a specimen I sent up myself. The child died with an enlarged liver and spleen, and albuminuria, not consequent upon the discharge from this abscess, and, therefore, not lardaceous disease, but rather diffuse syphilis. That is a very good example. Here is another, 4292, in the lower end of the radius, showing central disease of bone, leading to the formation of a cavity.

So we can find in the museum only two varieties of central abscess of bone, one due to tubercle, and the other due to congenital syphilis. I hope to-day to convince you that there is a third variety, namely, that due to general septic infection. I shall base my grounds for this conclusion almost entirely upon clinical material. There is no specimen so labelled to bring before you, because we do not possess any, and all the patients treated in the way described have, I am glad to say, got well. One of the cases resembles so much, in its history and in certain points, tuberculosis of bone and joint, that at first when she came in I accepted the view that it was tuberculosis. The complete dislocation of one hip which she exhibits is so like what occurs in tuberculosis that for some time I looked upon her case as an example of that disease. But when I have related her history and shown you some points about the case, I hope to convince you that it is an example of acute central osteitis. I hope I make it clear that

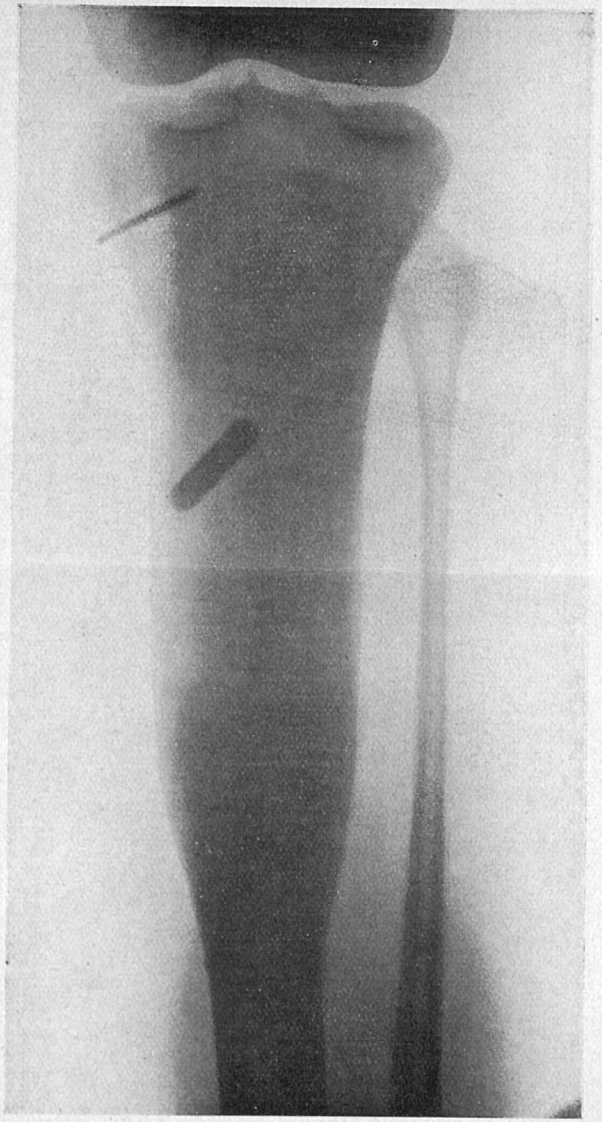

PLATE II.—Showing a piece of wire and tube in the bone—the former has been worn eight years, the latter five years.

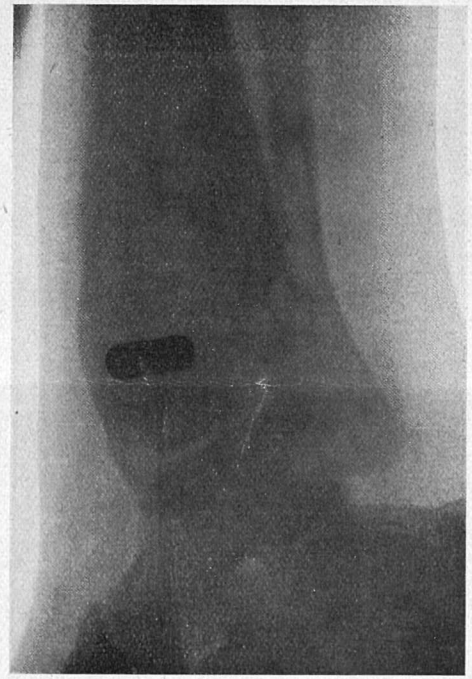

PLATE I.—Skiagram showing bismuth in the cavity.

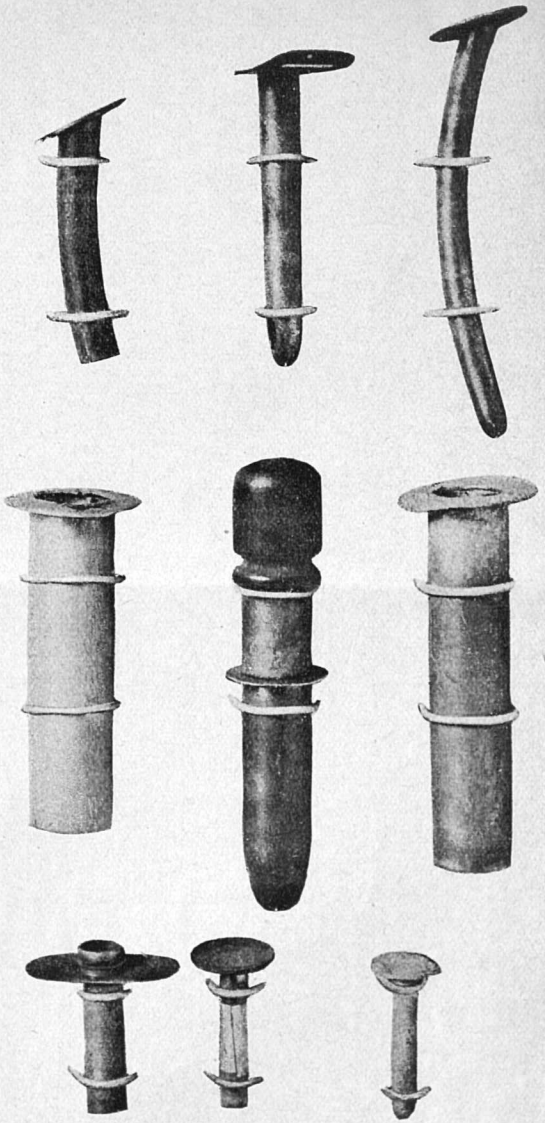

PLATE III.

Plates illustrating Mr. Charters Symonds' Clinical Lecture on "Chronic Abscess of Bone, and its Treatment."

by chronic abscess I mean a collection of pus in the centre of the bone, that the septic infection which gave rise to this abscess was deposited there during the period of an acute illness, that the bacillus, soon after its arrival in the bone, died, and became a dead structure, but the pus continued to irritate the bone, and so set up a gradual osteitis—a rarifying osteitis—which led to absorption of bone. Gradually, as the process extends over several years—and I will show you a radiograph from a case of thirty years' standing—it reaches the surface, as you will see depicted here, and when the surface is reached it begins to lay down a periosteal deposit. So that painlessly, very slowly, in fact, imperceptibly to the patient, the abscess extends. The patient, who had the condition thirty years, had pain for only three months in the lower end of the bone; yet one is convinced that the deposit must have been there thirty years. On pressing for a history, you will get out a confession of a small amount of pain.

This specimen, 4233, exhibits the structure of an abscess wall. It is a beautiful example of a cavity in the upper end of the tibia, involving the epiphysis and a portion of the shaft; and you will notice that the walls of the cavity are quite smooth, and the process which has gone on here has laid down a hard dense wall, which limits the cavity; it is a scar in the bone, the result of condensing osteitis. Though labelled tuberculous, I cannot but think that it had a septic origin. There is a membrane lining the cavity, and occasionally there is a sequestrum. The enlargement of the bone which ultimately takes place, you will see very well in this specimen, 4292, and to be due to a deposit on the surface. Next time I hope to be able to show you why one is able to be sure it is a deposit upon the surface. Some speak of expansion of bone as if it were possible to blow a bone out. You will understand that a hard resisting structure, like bone, cannot be spoken of as expanding. The process is a destruction of bone by a rarifying osteitis. And in this particular radius, 4292, if you look you will see the material which increases the size of the bone is laid down upon the surface. I will show you some other specimens next time. That will explain why the bone gets large.

There is very little difference in appearance between the abscess resulting from acute infective disease and that due to tubercle, but the contents are very different. The pus from a tuberculous abscess will show caseous débris and fatty degeneration of the walls, whereas in the ordinary septic abscess it will be creamy, thick, ordinary pus. In the tuberculous abscess the sequestrum will generally be hard, it will be white, it will be packed with tuberculous material, whereas in the abscess occurring in the acute process, it will rather have been macerated in the pus, and its interstices will not be packed with the white tuberculous material which we see in the other variety.

I will now show you some cases and radiographs to try and prove what I want to establish, namely, that we are dealing here, in many of these cases, with a non-tuberculous abscess. The first patient I have not been able to bring here to-day. I will make another effort, and it may result in her coming next time. I hope so, because hers is the most convincing of the cases. She came at the age of 42, complaining of rheumatism in her right ankle. On looking at it one could see there was enlargement of the lower end of the tibia, fairly well depicted in this skiagram (see Plate I.).

Here is another view showing considerable enlargement of the lower end of the tibia. She gave a most interesting history. She said that for three months she had had pain in this ankle—she called it the ankle, and you have to make out that it is the tibia. She had noticed this pain, then, three months. On going more carefully into the history she confessed that for ten years she had had "rheumatism" in the ankle, but she took no account of it, and had walked to her work. She had never observed any enlargement, which is curious, considering that the diameter was greatly increased. She attributed this omission to the fact that she had always worn shoes, and so the enlargement did not cause pressure. She evidently took very little interest in her ankles. I want to impress on you the fact that this woman had very little pain, for you will be told that these cases are extremely painful. She held a clerical position, and was a very intelligent woman.

She also had a scar on her opposite tibia, from which bone had exfoliated. She said that thirty years before, that is, when she was 12 years of age, she had an acute illness, with osteitis of one tibia, with loss of bone, and of one femur with loss of bone. She then remained well until a few months before she came here, when a little piece of bone exfoliated from the femur which was first affected.

At about the same time, but having no connection with the other point, she had increased pain in the lower end of her tibia. It is interesting that her acute illness was at 12 years of age, and that she remained well until she was 39, when she lost a small piece of bone from the femur, without much pain. She came when she was 42. The diagnosis of central abscess of the tibia was pretty clear. It was an uniform enlargement, tender, and slightly hot. And the X-rays helped us by showing, in the centre of the bone, a slightly lighter colour, which is said to indicate a central abscess. I shall never forget the interest which this case aroused, for in this spot, when it was the old theatre, I was giving a clinical lecture, and selected this case. I got my dresser to trephine the bone, and as he worked through, out came a considerable quantity of pus, thus demonstrating the presence of an abscess. My reading of it would be that this patient had an acute illness, starting in necrosis of the right tibia, when she was twelve; that at that time a septic deposit took place in the lower end of the left tibia. The organisms quickly died, but the pus remained as a chronic irritant, and, during the thirty years, gradually led to destruction of bone and the formation of this cavity. That, I believe, would be the correct interpretation of this case, because during those thirty years there was no moment when she was ill, neither is there any history of an injury; moreover, the patient is not a tuberculous subject. The necrosis she had in the tibia and femur was clearly due to ordinary infective processes. So I write her case down as an example of acute infective abscess of bone. In this skiagram (see Plate I.) you see a black area; that is bismuth, which was put into the cavity, but it does not show the full size, for there was about a teaspoonful of pus. She was treated by a silver drainage tube, with which she went to her work very soon afterwards, walking to and fro to her office. This method of treating these cases has not been generally adopted, but is one which has proved so successful in my hands that I am justified, after twenty years' experience, in recommending it to you as the best and simplest method.

Gradually the thickened tibia moulded down and became smaller, and then it became normal, the tube was removed, and the cavity closed. and she got well. Such a patient cannot get well until full absorption has taken place and the bone has been reduced to its normal size. That is in passing, to show you how she got well. I will ask the next patient, Annie H., to walk across the theatre. She came in 1906, on account of a sinus in the upper end of the tibia, and it was the hip condition that led to a diagnosis of tubercle. You notice she exhibits the typical walk of a case of dislocated hip-joint, with the resulting lordosis. The sinus had been discharging eight years, and was septic. I opened it up and found a cavity containing pus; it was drained by a metal tube. During the eight years she had been subject to frequent attacks of pain, swelling, and illness due to septic changes in this cavity.

When we put in the silver drain, at once all her attacks of septic infection disappeared, the tibia began to mould down to its normal size, though it had been very much enlarged, and she got well. The long duration of the illness, her age, and the septic character of the sinus and the dislocated hip suggested tuberculosis, but, on going into her history, it proved to be a most striking and interesting one, and most instructive. I learned from her elder sister, who then looked after her, that when this patient was 12 years old she had a very acute illness indeed, so that her life was despaired of. She got up from that illness with a dislocated hip, and with the sight of one eye lost, but she was able to enter service and discharge the duties of a cook. At that time there was some pain in this leg, but not very much, and it was not until some time afterwards, namely, when she was 17, *i.e.*, five years after the acute illness, that an abscess formed in the upper end of this tibia.

I think that history is suggestive of an acute general illness beginning, not in the tibia, but somewhere else, and resulting in a general infection, and, for some reason, it attacked the right hip, and led to softening of some of the ligaments, the ligamentum teres especially, and the pathological displacement of the joint. So, I think, I am justified in interpreting it, and it does not require an extraordinary explanation. She had also a septic deposit in this spot, which remained for five years, and then it broke and discharged. If a person has one abscess of bone, why should he not have two? Why not have three, for that matter? In this patient there were two. When she came in first there was a second swelling, which I did not like; it was thought to be a second abscess, but it quieted down. In 1910, that is, four years afterwards, she came back with consider-

able pain and swelling of bone in this site, and I trephined and opened the abscess. One of these drains she has been wearing four years, the other eight years. One is a hollow tube, the other a simple piece of silver wire. As long as she keeps the silver wire in she remains well. It was removed once after a year, and once after two years; she got recurrence of infection and pain. I have not seen her for three years until now, and I am astonished at the condition of this bone; formerly is was an inch and a half in diameter across the front, now it is nearly normal (see Plate II.). She is, therefore, undergoing spontaneous cure as a result of this drainage. I do not find any other drainage will get these patients well. So I claim this case as one of acute central osteitis, the result of a general infection, with a quiescent deposit in the upper end for five years, and in another centre for 17 years, and the hip-joint in a condition of pathological dislocation, the result of acute infection. So we must take this case out of the category of tuberculosis and place it among the instances of acute central osteitis.

We have all seen, especially in the past, cases in which these abscesses become septic, and go on and extend to a joint, and, as I shall show you in a moment, the joint may become destroyed. They may be packed, they may be drained with rubber, but they will not get well; they will still continue to progress. You see how well this patient is; with a small drain she gets about, and for eight years she has been able to do her work, except when she got a second abscess; and I know of no method which is so good as this. If you label a person tuberculous, especially at the present day, you do him or her an immense disservice if it is not true; you spoil their chance of obtaining employment. This patient was labelled tuberculous, but very good people were looking after her, so they kept her on, but the labelling of a case tuberculous will in many cases result in their dismissal.

I now want to mention a man, who shows you what can be done, and illustrates a curious point in the history of these cases. This was a fine, strong, able-bodied man, who came with a sinus in the lower end of his tibia. He was 32 years of age. At 13 he had acute necrosis of his tibia. This healed, and he worked for eight years. At 24 he had an abscess in the upper end of his tibia, that is, after an interval of 11 years. That was operated upon, and got well. At 28 he came with a swelling of the lower end of his tibia, and that was opened and drained, and he was doing very well. However, some friend, or medical man, not observing my special caution that the drain should be retained, removed it, and the orifice closed. The interesting thing is that the cavity remained closed for some four years, during which time he worked. He came back to me with a recurring abscess in the lower end of the tibia, with the bone much larger, the skin red, and the ankle joint a little painful. It was again opened and drained, and immediately the bone began to subside. This patient drove a motor omnibus, and you know what that means, working the brakes with the feet, and so on. I told him he might safely continue to drive so long as he kept his tube in. The tube was kept clean by the district-nurse, and he was able to earn his living. While he was at his work I saw him from time to time, and watched the gradual moulding down of the bone. So there was an acute abscess, caused by a deposit in the lower end of the tibia many years before, then after a quiescent time, the abscess is opened and drained; then it closes, remains closed a few years, and then recurs. Unfortunately he got acute appendicitis, went into a hospital, and died of it, so I cannot show him, nor relate anything further about the progress. I wish I had had the opportunity of getting the specimen.

Another case was that of a lad of 17, sent to me as a case of tuberculosis by my friend Dr. Evison, of March. The boy came complaining of his ankle—it is always the ankle. He was said by another to be suffering from neuritis, a late result of rheumatic fever. The enlarged lower end of the tibia was typical in every way. It was hot, a little tender, the ankle-joint moved well. He suffered some pain, especially at night, and from time to time he had acute pain.

His history was very interesting. He was a school-boy, and, feeling seedy for two or three days, he was put to bed. His temperature was 102·4°, and he had intense pain in his back. He had general pains all over him, but particularly pain in the left ankle, so-called, and he was said to have rheumatic fever. He was ill during this school-time for eight or ten weeks. His temperature never became higher, in fact, it subsided pretty quickly. So, whatever his illness was, we must write it down as sub-acute. He completely recovered and could walk, but

for three years he did not play games. But he walked, and continued at school, helping with his schooling by becoming a pupil-teacher. I recognised the disease as central osteitis, occurring from a deposit three years before.

Now, here is the surprise in the case. On the inner side it was tender, and there was one specially tender spot, an indication, as a rule, that the pus is near the surface. I thought this was an easy case, and that we should trephine it without difficulty. We took out a piece of bone, but did not find pus. This was rather a shock. I gouged through until I got over to the opposite side; yet I did not come upon pus. We put a drill downwards from the first trial, but there was no pus yet. Then we went upward, but there was none. You might have said I had now done enough, but I was positive there was pus. So I worked away, partly with a small scoup and partly with a drill, until I got very close to the articular surface, when I saw a membrane, looking like synovial membrane. On puncturing this, out came a drop of pus. It was quite dramatic, for the cavity was not a quarter of an inch in diameter; it had been the cause of all the patient's trouble. It was a long way to drain, but I put in a curved rod of silver wire, and sent him to run about on the sands at Sandown. He lost his pain and got well after eight months, and the tibia has moulded down, and is to-day normal. So I think one is justified in claiming this also as an example of septic central osteitis. There is no tubercle about him. Why did he get that centre there? Of all the bones of his body, why was it at that particular spot? This is not a solitary incident in the pathological history of these cases. A lieutenant in the navy had a general illness, which was labelled influenza. He had pains in many joints, but all recovered except the right knee. I opened that knee-joint and found it to contain pus and serum. Why is it that in pyæmia you get an elbow-joint or a finger-joint picked out? Think of it; there is some explanation for it. The only one I can offer is, that it is due to a general infection, to begin with, and then some accidental injury ruptures the small vessels, and permits the escape of the septic organisms, and the formation of a localised abscess. Probably that is the explanation.

I think it is desirable that in this connection everybody should remember the remarkable experiments of Cheveau, of Lyons. He was called upon to investigate the cause of sloughing of the spermatic cords in rams, which, as you may know, are in France unsexed by twisting the spermatic cord. In several instances gangrenous sloughing occurred. Cheveau took the anthrax poison, a common cause of death in animals, and injected six rams with a dose which would make them ill, but would not prove lethal. These six ran a temperature, but got well. He took another six rams and injected them with the same dose, and then had the operation of bistournage performed upon them. The spermatic cord was twisted, and became gangrenous. He took another series of rams and had the spermatic cord twisted; they were normal, and he had no trouble with them. Why did the rams that had not been injected become gangrenous?

On investigating the pasture where these rams fed, he found luxuriant grass had grown over the place where sheep dead of anthrax were buried; and the conclusion was clear: that these animals had obtained the poison from the soil, and that, while ill with that infection, the spermatic cord had been twisted and had become gangrenous. The explanation is that the infecting material is circulating in the blood, and a slight injury — it may be unnoticed—determines the rupture of a few blood vessels, and at once the septic organism escapes and we get an abscess in bone, an abscess in a joint, or what not. The whole process suggests the importance of resting these patients very carefully as long as the septic infection persists.

Here is another case, for which I am indebted to Mr. Miller, of Lambeth Infirmary, whom some of you knew as house-surgeon to Sir *Arbuthnot Lane*. It is a very interesting case as bearing on this subject. He started with acute necrosis of the humerus, and was operated upon over a year and a half ago. He had been rather seriously ill. While he was lying in bed there was discovered, almost by accident, an abscess over the metatarsal bone of the second toe. There was no pain. An abscess was found in the interior of the bone, and there was a small sequestrum as well. There was no rise of temperature. A little later I saw him again, with Mr. Stebbing, at Lambeth Infirmary. He had a tender point below the olecranon of the opposite ulna, and an enlargement which began to increase. We had a skiagram taken, and you will see the ulna is becoming enlarged. The small abscess

was opened, and he got well. There had been no temperature and nothing to indicate there was going to be a focus in his foot or ulna. I suggest that the material was deposited in the original illness of March, 1913. The abscess was opened about February last year. Mr. Miller showed him to me the other day with a swelling at the lower end of the humerus. There was thickening of bone all round from extension to the periosteum. An abscess was opened in the lower end of the humerus.

I will summarize by saying that these cases give a history of acute illness, and these foci are due to the deposit of bacilli, which remain quiescent for a long time. Does this occur only in bone? I think that is not the case. The brain, I think, offers us the best parallel. Some of you may have seen an old abscess of the brain; if so, you must have been struck, as I have been, and as everybody else has been, by the enormous thickness of the wall, clearly showing that an abscess may exist in the brain for a long time. The most famous case I know is that of Professor Schroder, an eminent gynæcologist. Eight years before his death he poisoned his finger at an autopsy. He was ill from the septic infection, and recovered. He went to Dublin, or Cork, and read an important paper on enucleation of uterine fibroids. Not long after he got home he suddenly died of rupture of an abscess in the brain. The history showed that the abscess must have existed at least eight years. It is most remarkable that this should have been possible in the case of the brain.

Another point I must mention now, although I want to go into it more fully next time, is that the method of treatment adopted has been extremely successful and all the patients who have worn a drain long enough have got well. I must mention that because some of you may not be here next time. I show you examples of the kind of drain, some aluminium, some silver; some are tubes, some are solid (see Plate III.). The girl whom you saw was wearing a silver wire—the discharge comes by the side of it. Nothing answers so well as metal: it prevents septic changes, and in every way is superior. As the cavity contracts you use smaller and smaller tubes for the drainage.

I had hoped to show you my original case, that of a man named Penn. But he got so well, after draining three or four abscesses in his tibia, that he has gone to Australia, where he is filling a remunerative post. This is Penn's tube, which he wore for ten years, and you will see it is merely a rudely-constructed aluminium nail. The whole of his tibia was affected.

I hope I have proved my point: that there is an infective central osteitis, leading to an abscess, and I would rescue the specimen I mentioned from the tuberculous series, and put it as an example of the condition I am talking about. It shows very well the gradual absorption of bone, where the abscess has reached the periosteum, and where it is about to perforate.

Abstract of Summary of Anæsthetics and Operations for the Year 1914.

The number of cases in which general anæsthetics were administered was 7675, among which were 129 intratracheal insufflations of ether, and 11 of C.E. Spinal anæsthesia was also employed on 75 occasions, and on 39 occasions spinal analgesia followed by a general anæsthetic. The total number of operations was 7,309 in Wards (Bright Ward excepted), Special Departments, Out-Patient Departments, and Surgeries. There were four cases of death under anæsthesia reported to the Coroner, particulars of which are furnished in the appendix. In one case according to the verdict of the jury, the death was "accelerated" by the anæsthetic, and in another the "anæsthetic could not be excluded."

There have been 6,229 cases of general anæsthesia in the Dental Department; 5,903 under Nitrous Oxide Gas, 321 under Ethyl Chloride, and 5 under A.C.E.

Operations done on the medical side are entered under the assistant surgeons corresponding to the physicians or assistant physicians in charge of the wards, the table below showing how many operations are actually performed in these wards:—

Anæsthetics.	
A.C.E.	149
C.E.	1,548
Chloroform	321
Ether (including Gas and Ether)	2,254
Gas, and Gas and Oxygen	1,687
*Intratracheal Insufflation of Ether	129
Intratracheal Insufflation of C.E.	11
Intravenous Ether	1
Spinal Analgesia	75
Spinal Analgesia followed by a General Anæsthetic	39
Other Anæsthetics and Sequences	1,536
	7,750

*In one case C.E. was also given.

ADMINISTRATION OF ANÆSTHETICS.

Staff Anæsthetists	1,707
Visiting Staff	128
Resident Surgical Officer	149
House-Officers	4,107
Clinical Assistants	582
Other Qualified Men	1,077
	7,750

OPERATIONS.—TABULATED ACCORDING TO WARDS AND DEPARTMENTS.

Astley Cooper	383
Cornelius	293
Lazarus	324
Job	403
Naaman	320
Luke	302
Patience and Samaritan	413
Evelyn	94
Charity	309
Dorcas	368
Lydia	317
Martha	333
Eye Wards	656
Addison	41
Mary	42
*Stephen	46
Esther	51
Queen Victoria	437
Clinical	63
Isolation	5
Out-Patients	1,605
Front Surgery	379
Back Surgery	72
Light Department	52
Massage Department	1
	7,309

*Officers' Section from November.

Turning to the General Wards, it may be noted that the totals of operations are as follows:—

Surgeons	865
Assistant Surgeons	1,031
Specialists	94
Resident Surgical Officer	672
House-Surgeons and Assistant House Surgeons	591
Surgeons' Dressers and Assistant Surgeons' Dressers	625
	3,878

the remaining 27 operations, bringing the total up to 3,905, were performed by other operators.

It should, of course, be remembered that all operations in Wards by Dressers and Resident Staff are performed under the supervision of the Resident Surgical Officer or of the Surgeon-in-Charge, and that no account is taken of operations done either under local anæsthetics or without anæsthetics at all.

Operations in the Obstetric Department (Queen Victoria and Patience Wards) number 471, of which 260 were performed by the Obstetric Surgeons, 81 by the Obstetric Assistant, 117 by the Obstetric Residents, and 7 by Dressers, while 6 operations were performed by other operators.

The operations upon Ophthalmic cases in the Wards number 223, of which 25 were done by Ophthalmic Dressers, 9 by the Ophthalmic House-Surgeons, 17 by the Ophthalmic Assistants, 152 by the Ophthalmic Surgeons, and 20 by other operators.

There were 460 operations for Throat and Ear Diseases in the Wards; 364 by Surgeons, 4 by the Resident Surgical Officer, 12 by the House-Surgeon, 11 by Clinical Assistants, 50 by Dressers, and 19 by other operators.

In the Orthopædic In-Patient Department 60 operations were performed; 57 by the Surgeon, 1 by the Clinical Assistant, 1 by the House-Surgeon, and 1 by Dressers.

In the Genito-Urinary Department 81 Ward Operations were performed; 44 by the Surgeon, 11 by the Resident Surgical Officer, 12 by Dressers, and 14 by other operators.

In the Front and Back Surgery 451 operations were performed; 5 by the Resident Surgical Officer, 77 by House-Surgeons or Out-Patient Officers, 1 by the Clinical Assistant, 366 by Dressers, and 2 by other operators.

In the General Out-Patient Department 455 operations were performed; 13 by Surgeons, 28 by House-Surgeons, 409 by Dressers, and 5 by other operators.

In the Special Out-Patient Departments 2 operations were performed upon Eye cases; 2 for Obstetric cases; 874 upon Throat and Ear cases, of which 24 were by the Surgeon, 80 by Clinical Assistants, 743 by Dressers, and 27 by other operators; 255 in the Orthopædic Department, 138 by the Surgeon, 66 by the Clinical Assistant, 44 by Dressers, and the remainder by other operators; in the Genito-Urinary Department 17, in the Light Department 52, and in the Massage Department 1.

APPENDIX.

1. Fred. C., æt. 31, was admitted to John Ward under the care of Sir Cooper Perry on January 14th, 1914. He had 13 fits during the day before admission. There was a history of a similar attack three years previously, and of an aural discharge which had stopped fourteen days before admission. The fits were unilateral, and the temperature and respiration rates high. There were three fits after

admission, but on the following day they stopped, although the patient remained comatose. On January 16th the fits returned, and the patient's condition became markedly worse. Sir Cooper Perry called in Mr. Layton, and it was decided that cerebral exploration would give the patient his only chance of recovery. The operation was performed by Mr. Layton at 9 p.m. the same evening, the patient being almost pulseless at the time. C.E. mixture in the proportion of 2 : 1 was administered by the open method by a House Anæsthetist. One drachm only was used during the operation, which was terminated by the patient's death in half an hour's time.

The case was notified to the Southwark Coroner, by whose order Dr. Spilsbury performed a post-mortem examination. A glioma of the frontal lobe was found. At the inquest a verdict was given in accordance with the medical evidence, the jury adding a rider stating that the medical men concerned in the case had acted with all skill, and had done everything possible for the patient, the Coroner expressing his concurrence with this opinion.

2. Lydia M. J., æt. 38, was admitted under Sir Alfred Fripp on March 10th, 1914, with a diagnosis of acute appendicitis. The Resident Surgical Officer's Substitute, Mr. Bromley, operated, and found the appendix normal, but there was an ovarian cyst apparently between the layers of the broad ligament. This was opened and a rubber drainage tube inserted, as it was found impossible to remove the cyst. The patient progressed very favourably till the early morning of the 13th, when, rather rapidly, she became worse. The pulse rate rose, and she became extremely restless, with coldness of the extremities. Mr. Bromley saw her again, and decided that there must be some internal hæmorrhage, and that the only chance of saving her life lay in immediate operation. The patient seemed much worse when she was removed to the theatre, and she was actually being infused before any anæsthetic was given.

Ether by the open method was administered by a House Anæsthetist. She had had less than a teaspoonful of the anæsthetic, and was still moving her arms, the administration having lasted about three minutes, when she began to vomit, and her breathing became much worse. The ether was stopped, and oxygen alone given. She almost immediately ceased breathing. Artificial respiration, strychnine, an injection of adrenalin chloride solution into a vein, pituitary extract into the heart, and artificial inflation of the lungs with air by means of the apparatus for administration of ether by the intratracheal method, were all tried, but respiration could not be started again. The patient died before any incision was made.

The case was reported to the Coroner, an inquest was held, and the verdict of the jury was: "Asphyxia. Obstruction of the bowels from natural causes."

3. Samuel M., a porter, æt. 54, was admitted to Lazarus Ward under the care of Sir Arbuthnot Lane on August 6th, 1914, and died on August 13th, 1914. P.-m. No. 405.

The patient was a married man, and gave no history of any illness previous to the present one. He had had four children, of whom two had died in infancy, one had died in early life of tuberculosis, and the fourth, still alive, was suffering from the same complaint.

His illness had lasted for about eighteen months, and consisted in general abdominal pain, constipation, and debility. His symptoms were temporarily relieved by laxatives, but medical treatment had failed to effect a cure. At the time of admission to hospital he looked fairly well, though rather pale. There was a swelling in the left hypochondrium, and on skiagraphic examination it was found that the stomach was markedly dilated, and the pylorus was obstructed. Pulse 44, temperature 95, respiration 24. Urine normal. On August 8th patient complained that food did not seem to leave his stomach properly, and on the 9th he vomited almost all day. On August 13th pylorectomy with duodenectomy was performed by Mr. Fagge, and immediately after the operation, before the patient had begun to recover from the anæsthetic, he died. The anæsthetic employed was ether, administered by a House Anæsthetist.

At the autopsy the heart was found to be small and wasted; the coronary arteries were atheromatous. The lungs were exceedingly œdematous. The part of the stomach left was quite free from growth, and no peritonitis had occurred. No metastases were found.

The verdict of the Coroner's jury was as follows—"Samuel M. died in Guy's Hospital while under the influence of a general anæsthetic known as ether (open method) for a surgical and necessary operation duly performed to remove malignant growth at the distal end of the stomach, from heart and respiratory failure due to shock of the operation and accelerated by the administration of the anæsthetic. And further, the jurors do say that such death arose by misadventure."

4. Florence S., æt. 44, was admitted on Monday, February 9th, 1914, into Mary Ward under Dr. Hale White suffering from intestinal obstruction, which it was thought possible to relieve medically. She vomited at intervals and remained constipated till Tuesday morning. Her general condition also remained unaltered and her temperature normal, but there was some pain chiefly in the left hypochondriac region. Dr. Hale White saw her on Tuesday afternoon, when it was clear that she had rapidly changed for the worse. No definite diagnosis was made, but Mr. Hughes was called in, and agreed that immediate operation was necessary to relieve some abdominal crisis. Accordingly patient was removed to the operating

theatre and ether administered by the open method on a Schimmelbusch mask by a House Anæsthetist. The pulse, which was bad to begin with, improved with the anæsthetic, which she took well. Mr. Hughes infiltrated the abdominal wall with novocain to diminish shock, and rapidly opened the abdomen to disclose extensive fat necrosis and a hæmorrhagic pancreatic cyst. Immediately on the opening of this cyst the patient became collapsed, and survived only a few minutes.

At the post-mortem fat necrosis was very general. There was severe hæmorrhagic inflammation of the pancreas, but no cause such as a stone in the ampulla of Vater to account for the condition.

On the evidence of Dr. Spilsbury, a verdict was returned that death was due to acute hæmorrhagic pancreatitis, hastened by operation shock, and he was unable "to exclude the anæsthetic."

Papers by Guy's Men.

Kenneth Black, F.R.C.S.: Dupuytren's contraction. *Brit. Med. Journ.*, February 20th, 1915.

Major C. E. Pollock, R.A.M.C.: Outfit for Sierra Leone.—*Journ. Roy. Army Med. Corps*, November, 1914.

The late Sir Robert M. Simon, M.D., F.R.C.P.: A case of Ménière's disease.—*Brit. Med. Journ.*, February 13th, 1915.

E. W. Ainley Walker, M.A., M.D., and others; Typhoid and paratyphoid infection in relation to anti-typhoid inoculation.—*Lancet*, February 13th, 1915.

Philip Turner, M.S., F,R.C.S.: Pulsating tumour of the scalp.—*Proc. of Roy. Soc. Med., Sect. for Study of Dis. of Children*, January, 1915.

Arthur F. Hertz, M.D., F.R.C.P.: Achalasia of the Cardia (so-called cardio-spasm).—*Ibid., Clin. Sect.*, January, 1915.

—— and C. H. Fagge, M.S., F.R.C.S.: Gastric ulcer; spontaneous gastro-jejunostomy; perforation of gastro-jejunal ulcer; operation: recovery.—*Ibid., Clin. Sect.*, January, 1915.

T. G. Stevens, M.D., B.S., F.R.C.S.: Two cases of hysterectomy for ante-partum hæmorrhage.—*Ibid., Obst. and Gyn. Sect.*, January, 1915.

H. L Eason, M.D., M.S.: Bilateral temporary hemianopia; rapid and permanent recovery of vision after the administration of thyroid extract.—*Ibid., Sect. of Ophthalmology*, January, 1915.

J. Macdonald Gill, M.D. Lond.; Infantile paralysis, *Med. Journ. of Australia*, January 2nd, 1915.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR,—The following may be of interest to some of your readers, and I trust may throw some light on the nature of the Parasite.

A month ago a baby was bronght to me with a very inflamed painful swelling on the back between the scapula and the spine. Noticing a blackish spot I squeezed with my thumbs, and out shot a thick grub about one-eighth of an inch long, and having very active movements. The mother informed me the child had cried continuously for two days and nights. Boracic fomentations, and touching the central hole with pure carbolic acid, cleared up the trouble.

Three days ago, a gentleman, who had been in the Low Veldt collecting Hut Taxes, called on me in a miserable plight. He had had no sleep for three days, and he said he "literally felt alive, though half dead." I examined him and found he had no less than twenty of these swellings, chiefly on the legs, abdomen, penis, and scrotum. I squeezed out of each a similar short fat grub, and touched each central aperture with carbolic. Relief was immediate in spite of the intense inflammation set up, some of the areas being the size of half-a-crown, elevated and brawny; on the legs there was a good deal of œdema, T, 101°. I put the grub under a low power and found its movements very active, it had about six spidery legs, and was covered with black hooklets.

I am informed that an egg is deposited by a fly somewhat bigger than the common house fly, though how this can have happened in the case of the baby, a white child of well-to-do parents, I cannot conceive.

These are the only cases I have seen here over a period of four years.—I am, dear Sir,

"Monkhof" Sabie, Transvaal, Jan. 20th. 1915.

Faithfully yours,
W. H. DIXON,
(late Guy's).

Trade Notices.

WE have received from Messrs. Melbourne, Hart & Co., of 19, Basinghall Street, a sample box of cigars of the brand known as Melarto.

The manufacturers claim for these goods that they are made from Havanna Tobacco in this country, and from the method of their manufacture, and the character of the leaf employed, they contain but a minimum of nicotine. The Residents and ourselves have carefully checked these statements, and from personal experience we are in a position to endorse these claims; the cigars are exceedingly mild and of good flavour. Many cardiac patients who have been of necessity forbidden the solace of tobacco will now be able to enjoy the fragrant weed.

Messrs. Jewsbury & Brown, of Manchester, have sent us a copy of their "Posological Tables, B.P., 1914," which contains the comparative doses and strengths of the various Pharmocopœial articles for 1914 and 1898. The book is excellently got up and contains very useful information for busy practitioners, who should secure a copy at once by writing to the publishers at Ardwick Green, Manchester.

The Care of Soldiers' Teeth.

The appointment of Dental Surgeons to serve in the Army, is, I believe, shortly to be an accomplished fact, and one regrets that so important a matter as the care of the teeth has been left in abeyance for so long.

At the medical examination of the men of my battalion after mobilization, more than half of the number had defective teeth, and would soon have gone sick on active service. On taking down the names of these with more than two bad teeth I had a list of 328 men, one third of the battalion! My difficulty was how to deal with them. This was solved by discovering in the ranks a Guy's dental surgeon, Manton King, serving as Drummer-Sergeant. He volunteered at once to do what he could with this large number, and he has succeeded in making their mouths clean. We provided him with a syringe and anæsthetic solution, and he went on steadily with the work until he had done all that he could with the material at his disposal. He has furnished me with a report and a schedule giving the trades of the men when in civil life, the number of men in each trade, the number of defective teeth in each man, and the average number of defective teeth in each trade.

"Company rolls of Foreign Service men, marked 'defective teeth' at the medical examination, were made. Treatment was limited to extractions, and scalings were done in bad cases. Local anæsthesia was used in the majority of cases. The teeth of all the men examined were found to be in a very bad state, and for a large number of cases dentures should bo provided. Treatment was optional, but most of the men attended for the necessary extractions, although a number refused because no dentures could be promised. Men suffering from toothache were put on the 'Morning Sick Report,' and were treated before the men on the dental list prepared for the day. Up to the present 328 men have been treated for extractions and 15 for scaling, the number of extractions being 1,749, an average of 5·3 per man. The following table is made out from the men examined and does not include odd cases. It shows the men grouped in their civil occupations. The number of defective teeth, total and average. The percentage cannot be obtained, as only those with defective teeth were examined. No means of doing 'Fillings' (of which there is a large number) is provided."

	OCCUPATION.	No. of Men examined.	NUMBER OF DEFECTIVE TEETH.																							Total Number of Teeth.	Average.
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25		
1	Groom	3									1		1									1						40	13·3
2	Milkman	4							1			1			1		1											45	11·25
3	Brewer's Labourer ..	6						2		1	1							2										61	10·16
4	Bricklayer	3					1					1					1											30	10·0
5	Engineer	7			1	1				1	1			2									1					69	9·85
6	Butcher	5			1				1		1			1					1									48	9·5
7	Farm Labourer	11		1		2	1	1		2		1							1		1		1					104	9·45
8	Clerk	8		2	1			1				1			1	1												74	9·25
9	Carpenter	11		1		1			2			1		1	1	1										1		101	9·18
10	Plumber	6		1	1				1		2				1	1						1						55	9·16
11	Labourer	28	3	1	1	2		1	2	2	9	1	1	1		1	1		1		1							231	8·25
12	Corn Trade	4						1		1	2																	32	8·0
13	Painter	4		1						1	1			1														31	7·75
14	Baker	4					1	1		1		1																29	7·25
15	Gardener	30	4	2	4	1	2	2	2	2	4				2	1	2	1	1									215	7·16
16	Fishmonger	4				1			1	1	1																	28	7·0
17	Footman	4				1			1	1	1																	28	7·0
18	Woodman... ...	3	1						1						1													21	7·0
19	Blacksmith ...	4					2	1					1															27	6·75
20	Grocer's Assistant	3				1		1	1																			17	5·6
21	Miscellaneous ...	40	1	1	5	2	3	2	4	4	4	2	1	3	1	2	1	1	1		1		2			1	1	350	8·75
	TOTAL ..	192	10	9	14	12	10	13	17	17	28	9	5	9	8	7	6	4	5		2	3	2			1	1	1,636	8·52

Without King's valuable help these men could not have received adequate attention, and my morning sick reports would be filled with toothaches, dyspepsias, &c. It seems incredible that men can go about with their mouths like "cesspools." They all possess toothbrushes, though they seldom use them. The importance of the preservation of the teeth should be drilled into them while children at school, and when they join the army they should be periodically examined by Army Dental Surgeons.

My experience is undoubtedly shared by many other regimental medical officers, and after reading in the "Passim" editorial in the GAZETTE of January 30th, of the good work done for the army at Guy's, I thought it would interest you to know how we have dealt with our "defective teeth" here, where there are no local dentists.

G. BLACK,
Major R.A.M.C.
Attached 4th Batt. Royal Sussex Reg.

Letters from Men on Active Service.

Dr. Dunn has very kindly sent us the following letter sent to him by a one-time patient, straight from the trenches:—

1st Battalion Royal Fusiliers,
Expeditionary Force,
20th January, 1915.

Dear Sir,—I hope that this letter comes as a pleasant surprise. Do you remember when I asked you in Naaman Ward, on visitors' day, if I would ever join the army again with my hand? Well, needless to say the operation turned out successful,, and while I may, I wish to thank you, the matron, and nurses of Naaman Ward for their past kindnesses

I have been out here since the 7th of September, 1914. So it is needless to say that I have had a few exciting moments the last four months. Our artillery fire is simply marvellous! It is one of the wonders of the war the way they drop their shells just where they are wanted. Last week, for three days running at 3 p.m., they shelled the German trenches unmercifully for practice.

It is terrible to watch, as every shell tells; we have no dud ones like them. We shelled them principally with lyddite and common shell (coal boxes). Our lyddite is the most terrible of all the shells used out here It is similar to a coal box, for the splinters that fly in all directions on concussion weigh anything from 2 ounces to 30 pounds; but where its terror lies is in the sulphur, which hangs in a cloud where it bursts and suffocates any living thing within a radius of 100 yards. The majority of the shells went through the parapet or bang into the trench booby hutches; men, etc., were blown from 20 to 30 feet high; they lost their heads, some even trying to escape by leaving their trench. I am afraid that Guy's would not hold that afternoon's work.

When we took this position some six weeks ago, they shelled us more incessantly, never leaving off for six days; it averaged about 300 shells in 24 hours. We left this position, after being relieved by another regiment, to go to billets for a short rest to our left rear of the old position we were just relieved from. You can better imagine our surprise than I can describe to find the enemy there. We had been practically surrounded and outnumbered by about 20 to 1. The order came down to stand to and prepare to reinforce another brigade. The enemy came on four deep, to be mowed down by our guns, infantry, maxims, and artillery. Next morning there was a dead German hanging on the barbed wire fence that was in front of the ditch which had been used at the start as a trench. He was like a scarecrow warning the others to knock off.

The field in front was strewn with their dead. The same night, under cover of the darkness, we buried the lot to save fever. Hardly had we got back, when they came on for another attack, messing up the ground for us to clean up again.

We had a pretty fair Christmas, only the legs of mutton were not done, so we had to fall back on the old reliable B.B. I went up and had a look at the troops in front of us, as we had a private truce in our part of the line. They were very weedy with their dirty yellow complexions and torn uniforms; they looked as disappointed a lot of men as one could ever find, in fact, they were not men, as their average age was about 18 years. They wanted us to have cigars and wine (probably looted) with them, but, of course, we refused—there is no trusting them.

The weather is nothing else but rain; we are above our knees with water in places. The other night a booby hutch fell in on a couple of chaps; the sentry woke us up, and in less than twenty seconds we had them dug out. I hope this letter will be of some interest to you and your patients. Kindly remember me to the sisters and nurses.—From your ever grateful patient,

GORDON FOCHER.

Reviews, etc.

The Midwife's Pocket Encyclopædia and Diary. Price 6d.

The Nursing Mirror Pocket Encyclopædia and Diary. Price 6d.

These are published by the Scientific Press, Ltd., and are illustrated pocket guides for the midwife and district nurse. Both books are alphabetically arranged, and a remarkable amount of information and advice is contained in very small space. The Scientific Press has also published "The Legal Engagement and Case Book for

Midwives and Maternity Nurses," by Sarah MacDonald, price 1s. The midwife who provides herself with this book will find many valuable hints as to arranging and managing her cases in the most methodical and business-like way.

A fifth and enlarged edition of Dr. Ralph W. Leftwich's "Index of Symptoms," has been published by Messrs. Smith, Elder & Co., on February 11th. The new edition contains a large number of new symptoms and many new tests, while the interlineary notes have been much amplified. Further, an attempt has been made to devise a scientific classification of symptoms. The increase in matter has involved an increase in bulk, so that it is no longer a pocket book, but a book for the desk.

A Manual of Chemistry. By A. P. Luff, M.D., B.Sc. (Lond.), F.R.C.P., F.I.C., and H. C. H. Candy, B.A., B.Sc. (Lond.), F.I.C. (Cassell and Company, Ltd.). Price 8s. 6d. net.

The fifth edition of this popular manual has been so thoroughly revised that it is practically a new book.

The descriptive part of the Inorganic Chemistry has been extremely well done, and is a very great improvement on the previous editions. The section on Organic Chemistry, however, is not nearly so good, as the beautiful simplicity and generalisations of this branch of chemistry have not been brought home clearly to the mind of the student. The short section on Practical Chemistry should be distinctly useful.

But it is disappointing to find that the Introduction still retains many of those absurdities which made this text-book one of the curiosities of chemical literature. We append a selection of these:—

"The atomic weight of an element is the smallest part by weight of that element which is present in the gaseous molecule of any compound." (P. 21.)

"Atomicity is another name for valency." (P. 23.)

"Therefore each molecule of hydrogen must contain at least two atoms of hydrogen. For this reason we represent the molecule of hydrogen by H_2." (P. 30.)

"Therefore one molecule of oxygen must contain at least two atoms, and be represented by O_2." (P. 31.)

"the molecule of hydrogen evidently weighs at least two of these units, and we shall therefore call the molecular weight of hydrogen 2." (P. 31.)

We would also like to point out that the definition of osmosis, given on p, 41, is wrong; that the definitions of the three different classes of salts (p. 71) are completely inaccurate; that carbon monoxide in the atmosphere cannot be estimated by bubbling air through a solution of iodic acid (p. 226); that the gram (not the gramme) is the unit of weight used by English chemists; and that it is usual, and necessary, to ventilate a combustion apparatus with air before removing the absorption vessels. The authors also introduce a sign to represent reversible reactions (p. 83), and a classification of various kinds of isomerism (p. 453) which are quite different from those in general use.

It would also be better to discuss methylated spirits under ethyl alcohol instead of under methyl alcohol.

On Pharmaco-Therapy and Preventive Inoculation applied to Pneumonia in the African Native: with a discourse on the logical methods which ought to be employed in the evaluation of therapeutic agents. By Sir Almroth E. Wright, M.D., F.R.S. (London: Constable & Co., 1914.) Demy 8vo., pp. 133. Price 4s. 6d. net.

The particular susceptibility of the native to the ravages of the pneumococcus has long been commented upon by the medical officers on the Rand; two members of the Guy's colony in Johannesburg, Rogers and Hamilton (in conjunction with Dr. Brodie) recorded their own observations in this connection in the *Lancet* in 1897, in which they attempted to show the association of epidemic pneumonia and meningitis in the natives due to the pneumococcus, with epidemics of horse sickness due to the same micro-organism, and an expedition was actually on the point of leaving our Bacteriological Department to investigate the subject, when the South African War broke out.

The volume under review, deals with some aspects of the same subject, and is a reprint of the Report (originally published in the *Lancet*, December, 1912, and January, 1914) to the Witwatersrand Native Labour Association. It details the search by Wright, assisted by Parry Morgan, Colebrook, and Dodgson, for some means of checking the wastage from pneumonia amongst the native labourers employed in the mines.

The first part of the Report is concerned with laboratory experiments and clinical observations as to the value of æthylhydrocupreinhydrochlorate in the treatment of pneumonia, a drug advocated by Prof. Morgenroth as having a specific bactericidal action upon the pneumococcus.

The author and his assistants soon found that, in the human subject, the results obtained were by no means so brilliant as Morgenroth's experiments on mice might have led them to anticipate—moreover, the drug was found to be definitely toxic to nerve tissue, as shown by the occurrence of cases of amblyopia.

The second part deals with the author's attempt to evolve a method of prophylactic vaccination on the lines of his anti-typhoid inoculation. In this he claims to have been successful, by means of a primary injection of vaccine containing 1,000 millions of pneumococci, cultivated upon glucose blood broth, and followed by a second similar dose four months later; and supports his contention by statistical returns of the mass experiments which were instituted to test

the efficacy of the prophylactic inoculations. Which will probably appear more convincing to the ordinary medical mind than to that of the professional statistician. Time alone will show whether Wright's contention is well founded.

A critical perusal of the work would suggest that the author was anxious to enunciate those fundamental methods which "ought to be employed in the evaluation of therapeutic agents," that is to say, those which he, as an experimental physician considers logical, and the Witwatersrand Report was as good a peg as any upon which to hang his sermon.

Incidentally, Wright wages furious war against the non-medical ready reckoners who arrogate to themselves the right, after the manipulation of statistics, good, bad, and indifferent, supplied to them by other observers, to decide whether or no a given remedy shall be employed in a given disease.

The book which concludes with a complete six page catalogue of Sir Almoth Wright's publications, is written in the style which is so typical of our author at his best, and is well worth reading.

A Manual of Surgery, for Students and Practitioners (Rose and Carless). Ninth edition, revised by Albert Carless. (Messrs. Baillière, Tindall & Cox.) Pp. 1,355. Price 21s. net.

The very fact that this famous text-book has now reached its ninth edition, and has been translated into Arabic and Chinese, is the best proof that it contains just what a large circle of readers desire to know. In the new volume many additions and alterations have been made, but without altering the size of the book. A chapter on the therapeutic uses of light, heat, electricity, and radium has been added; salvarsan is fully described; arthroplasty and several other modern orthopædic measures receive a fair mention; and a temperate, though non-commital, treatment is accorded to the work of Sir Arbuthnot Lane on chronic intestinal stasis and its results.

On this topic, as on every other, throughout the book, Mr. Carless gives us practically no hint of his own views on the subject. He is content to give a complete and impartial account of the theories that have been advanced, and the results that have been obtained, and then he leaves us to form our own conclusions. Perhaps, in a students' text-book, it is better not to dogmatise too much, and certainly it is a fault for an author to state his own views and omit those of his opponents. But this policy of studied impartiality can be carried too far, and we feel that a less hesitating recommendation of early operation in cases of appendicitis, or probable appendicitis, is very much to be desired. As long as leading text-books vacillate, practitioners generally will hesitate, and lives will continue to be thrown away. In connection, again, with tuberculous arthritis, no definite rule is given as to the duration of splint-treatment; this is a point upon which students and practitioners are, as a rule, profoundly ignorant, and yet nothing could be more important. We hope that in future editions these two faults will be rectified.

In perusing the book one is struck with the wonderful all-round excellence of the chapters, and their completeness. Everything of importance seems to have been mentioned, and yet there is no padding and no mass of superfluous detail to obscure the main issue. The modern treatment of syphilis is described in detail, and it is pleasing to note that due prominence is given to the "warnings to the patient" that play such an important part in prophylaxis. It is unfortunate that the deleterious effect of recent administration of mercury or iodide upon the Wassermann reaction was not also mentioned. The old, incorrect classification of hip-fractures into intracapsular and extracapsular has been entirely given up, and instead has been introduced the nomenclature suggested some years ago by Mr. A. R. Thompson in his Hunterian Lectures.

If we offer any further criticism, it is not in any cavilling spirit, but in the desire to see this excellent book rendered still more useful and complete. We think that the chapter on shock might with great advantage be made very much larger; at present the whole subject—pathology, symptoms, and treatment—is squeezed into five pages, whilst no less than eighteen are devoted to aneurysm, now almost a relic of a bygone age! Yandell Henderson's theory, the importance of loss of fluid, and the question of adrenalin-exhaustion, should all be mentioned, and their practical bearing upon treatment described. The paramount value of morphia, as opposed to strychnine, when pain is a prominent factor, is insufficiently urged, though the value of radiant heat baths is mentioned.

Three points attracted our attention in the chapter on genito-urinary diseases: The great superiority of prostatectomy over "catheter life," in appropriate cases, is not mentioned, though abundantly proved by statistics; the use of the urethroscope in the diagnosis and treatment of strictures is omitted; and nephrectomy is described as indicated if the surgeon is *tolerably certain* that the other kidney is working satisfactorily. Surely, nowadays, nothing less than absolute certainty is justifiable, with the ureteric cystoscope at our disposal!

But these are merely isolated instances picked out amongst a mass of excellent work. The book, as a whole, is an admirable compendium of modern surgery; it includes all that a sound practitioner needs to know, written in a readable way, and illustrated sufficiently, though not extravagantly. Consequently, the price of the book is modest, viz., 21s., and we doubt whether anyone could get better value for the money.

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of the Published Writings of the late THOMAS BRYANT, F.R.C.S., Hon. M.Ch. R.U.I., Hon. M.D. Dublin, Hon. F.R.C.S.I.

COMPILED BY J. H. E. WINSTON, Wills Librarian.

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(To be continued.)

Births.

ADAMS.—On February 9th, at Lygon House, Cale Green, Stockport, the wife of Eustace H. Adams, M.R.C.S., L.R.C.P., of a son,

BIDWELL.—On February 4th, at Worthing Road, Southsea, the wife of Fleet-Surgeon Lawrence Bidwell, R.N., of a son.

JORDAN.—On February 4th, at 13, Upper Wimpole Street, W., to Dr. and Mrs. Alfred C. Jordan, a son.

Marriage.

YOUNG—HESLOP.—At Dover, by special licence, William Arthur Young, B.Sc., Royal Army Medical Corps, to Ina Heslop.

Death.

BINGHAM.—On February 7th, at the Kent County Asylum, Maidstone, of bronchopneumonia, Samuel Bingham, M.R.C.S., L.D.S., Acting Assistant Medical Officer, aged 67 years.

W. E. T.

GUY'S HOSPITAL GAZETTE.

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Passim.

LOOKING through the GAZETTES published since the beginning of the War, we find that more than 520 Guy's men are mentioned as serving either with the Army or the Navy. We are anxious to make this list complete, so will you please send in the name of anyone who is not on our list as soon as possible.

MR. ALEC SEABROOKE, our Senior Obstetric Resident, has taken a commission in the R.A.M.C., and left the Hospital on Monday last. "Puppy" Seabrooke is too well known to the younger generation of Guy's men to need any effusiveness from our pen, but on behalf of the Residents of Guy's we take this opportunity to wish him every success in his future career. Alec Stanger Seabrooke entered Guy's from Christ's College, Cambridge in 1908. During his career at Cambridge, and later at Guy's, he was the friend of a well known group of Cambridge men, all of whom have been brilliant, both professionally and as sportsmen. To him falls the honour of having done every Student and Resident Appointment with the exception of Ophthalmic H.S. During the last six months his services have been of special value to the Hospital, and having done his duty here, he has, of course, given his services to our soldiers. We shall always remember "Puppy" as a fine House Officer, possessing great sympathy for his patients, and always ready to assist his colleagues. His departure has caused a serious gap in our hospital life.

Mr. B. Burnside, recently returned from a Hospital in France, has been appointed Obstetric Resident.

WE desire to express our sympathy to the relatives and friends of Miss Margaret Ryle, daughter of Dr, R. J. Ryle, of Brighton, an old Guy's man, and sister of J. A. Ryle. Miss Ryle has done months of very fine work with the Russian Red Cross on trains running between Moscow, Warsaw, and the most westerly limit of the Russian lines; she has died as a result of an accident in Serbia, whither she had recently gone with a Russian detachment of Red Cross workers. Miss Ryle was a very brilliant girl, and all her life did splendid work for Liberty.

VACANCIES for qualified men will shortly occur in a Territorial Field Ambulance that will probably be going to the Front. Successful applicants will receive a commission for the period of the War in the R.A.M.C. Ex House-Surgeons and recently qualified men are specially desired. Apply to Capt. Tredgold, 47, Thames Street, Windsor, Berks.

ARRANGEMENTS have been made, by the good offices of the President, for a taxicab call between the Hospital and London Bridge Station, S. E. & C. R.

Sister Queen sends the following poem, but wishes us to point out that this is not her effort:—

THE DISTRICT "IF."

(With apologies to Rudyard Kipling).

1

If you can find your way about the Borough,
At any moment of the day or night,
If you can make examinations thorough
And diagnose if "transverse," "left" or "right,"
If you can hear the fœtal heart a-beating
And, spite of souffles, count each stroke with zeal,
And trace the fontanelles' precarious meeting,
And be quite sure it *is* a head you feel,

2

If you can trust yourself and not be shaken,
If you can make F.A.-s at break of day,
Then when you find, alas! you were mistaken,
If you can greet with smiles the B.B.A.!
If you are good at piecing "things" together,
If you can handle babies "blue" and "white,"
If you know when to stop and "wonder whether?"—
And when to heave a sigh and just sit tight.

3

If you can talk with Gamps and keep your temper,
If you can climb Queen's Buildings without fears,
If you can make you motto "spero semper,"
While waiting till the Charity appears,
If you know when to send green danger slips up,
And when your own shortcomings you must own,
Why then, aspiring midwife of the future,
The chances are—they'll let you run alone!

HUMOUR FROM THE THROAT DEPARTMENT.

A patient anxious to be under the care of our Throat Specialist, sent the following account of his disease:—

Brain Trouble.

1. Itching inside ear and a slight humour trickle, "passed away."

2. Next came pain on left side of head, in the morning after sleep (not lately).

3. My left eye became bad, the lashes sweeping the eyeball with humour discharge.

4. *Giddiness*, everything revolving, myself included, from front to rear.

5. A disposition to become "comatose," excessive snoring at night when sleeping.

6. While holding the nostrils together and swallowing, the concussion inside the left ear is far greater than the right ear.

E. H.,
Patient.

Appointments.

Civil.

H. A. Duffett, F.R.C.S., Medical Officer of the Children's Homes, Sidcup, of the Greenwich Union.

William A. Maggs, L.R.C.P., M.R.C.S., L.D.S. Eng., has been appointed Honorary Dental Surgeon to the King George Hospital, S.E.

Naval.

S. Worthington to the *Victory*.

Royal Army Medical Corps.

To be temporary Lieutenants:—F, R. Featherstone, S. H. Browning, T. H. F. Roberts, B. R. Parmiter, T. E. Roberts, H. J. Gater, C. R. Nicholson, C. S. Lane Roberts, L, R. Broster, E. S. Marshall.

The following Majors to be Lieutenant-Colonels:—C. E. Pollock, J. C. B. Statham, H. Hewetson, W. P. Gwynn, R. P. W. Barrow, L. Humphry, H. D. Packer, H. Simson, C. R. Evans, D.S.O., V. J. Crawford, D.S.O.

Lieut.-Col. G. T. Rawnsley, R.A.M.C., to be Colonel.

4th London Field Ambulance:—G. B. Pritchard to be Lieutenant.

1st London (City of London) Sanitary Company:—C. W. Ponder to be Lieutenant.

2nd South Midland Mounted Brigade:—A. G. Levy and H. J. Blackler to be Lieutenants.

3rd Welsh Field Ambulance:—Capt. P. C. P. Ingram, from attached to other than medical units, to be Captain.

G. W. Wheldon to be 2nd Lieutenant, 5th Battalion, Royal Fusiliers, Dover.

Temporary Lieut. B. B. Ham to be temporary Captain.

Attached to other than Medical Units.

To be Lieutenants:—H. A. Sandford, K. J. Keer, J. J. E. Biggs.

Colonial Medical Services.

West African Medical Staff:—E. H. Tipper, Medical Officer, Nigeria, to be Senior M.O.

D. C. H. D. Ralph, Medical Officer, Gold Coast, to be Senior M.O.

Pass List.

Society of Apothecaries.

The following candidate has been approved in the subjects indicated:—

Forensic Medicine ... L. A. J. Graham.
Midwifery ... ... L. A. J. Graham.

Tall *versus* Short Men for the Army.

Abstract of speech by M. S. PEMBREY in opening the discussion* at the Royal Sanitary Institute on February 9th, 1915.

THE ordinary standard for recruits was raised for a time during the opening stages of the War; it was soon restored, and later on was reduced when the so-called "Bantams" were enlisted. Can this lowering of the standard be defended, and, if so, are there other arguments than those of necessity? The official view that height in a soldier is an advantage is a reflection of the general view of the layman. There is often some truth behind an opinion which is held by the masses of the people. It is necessary, however, to consider the evidence, for popular views may be erroneous.

A definition of terms is a necessary preliminary to an examination of evidence. A man may be considered tall when his height is four or five inches greater than that of the average of his countrymen; on the other hand, he is short when his height is a similar number of inches below the average. All comparisons must take into account racial differences. The average height of the men of Great Britain and Ireland is uncertain, for there are not sufficient data. According to the figures collected by the Anthropometric Committe of the British Association for the Advancement of Science, the averages are: Scotch, 68·71; Irish, 67·90; English, 67·36; and Welsh, 66·66 inches. The mean of these is 67·66 in. The average for our army recruits during the period 1901-10 was 5ft 6in.

Even if the anatomical data were extensive, it would be impossible to estimate a man's capacity by height. Physiological estimates must be expressed in physiological terms.

The greater stature of the tall man is due chiefly to the length of his legs. It is difficult to judge the height of men sitting down, but the individual differences become apparent directly they stand up. Growth depends upon the correlated activity of certain glands which produce internal secretions. Qualitative and quantitative changes in the secretory activity of glands, such as the thyroid, pituitary, thymus, and the generative glands may result in retarded and defective growth, in the production of dwarfs, or, on the other hand, in excessive growth, such as giants. These two extremes are pathological, and need not be considered in detail. Associated with the influence of the glands of internal secretion are the effects of nutrition, work, and climate upon the growth of the body. A good supply of food, active exercise, and exposure to the stimulating effects of a variable climate, such as our own, will produce a sturdy growth, but all of these factors are subordinate to the racial influence.

The selection of recruits requires as much intelligence and experience as the selection of horses or cattle. The tape-measure can never serve as an accurate guide. The "points" of a soldier are related to the functions which he has to perform. The business of a soldier is to defend whole-heartedly the interests of his country; the test of his efficiency is not his height, nor his weight, nor his girth, but his ability to bear the physical and mental stress of active service, to march, to shoot straight, and to subordinate his own interests to those of the race.

If the question be reviewed in this light, it will be obvious that physiology and psychology are involved more than anatomy. The volunteer is better than the pressed man. At the present time the desire of the short men to fight is a psychological testimonial of their value; they are willing to give up good positions, to undergo hardships, and to bear, what is often the hardest part of all, the slight regard, or even contempt for the short soldier. Cromwell's army on the "new model" showed the value of the psychological factor.

The essential organs are in the head and trunk; these are often better developed in the short than in the tall man. The weight of the brain is relatively greater in the short man, but this anatomical fact is no evidence of quality. The reaction-time of the short man is not so long, and associated with this may be his greater alertness and pugnacity. The tall men of full proportions are heavy, slow, and docile.

The physiological reasons for the greater agility and activity of the short man are well founded in the relation between the surface-area and the mass of the body. The exchange of material is more rapid, and this involves all the systems of the body. There are mechanical advantages and disadvantages of height, but a consideration of these in relation to marching, digging, and exposure shows that the resultant is not against, but in favour of the short man under the conditions of modern warfare. As regards capacity for work, endurance, requirements of food and clothing, and resistance to disease, the evidence is in favour of the short man.

Finally, the test of experience shows that the fighting capacity of tall and short races, or of tall and short men of the same race, does not bear any relationship to height. No one can dogmatise upon the question whether tall or short men are the better soldiers. During times of peace height is a recognised standard for recruits, for most men will agree that a tall soldier is more imposing, dignified, and docile

*A full account will be published in the Transactions of the Institute.

than a short one. An unjustified bias may thus arise in favour of the tall man. When, however, a country is fighting for its life it is willing to give up appearances in favour of the real physiological and psychological qualities which make a man a good soldier, whether he be short, tall, or of average stature. The average man, other things being equal, is most convenient, for the extremes, the short and the tall men, must be graded if efficiency is to be obtained.

A Case of Congenital Syphilis.

S. C., æt. 9, was admitted to the Evelina Hospital for Children on November 11th, 1914.

The following family history was given. The mother was married when 18 years of age and had her first child nine months after. She has had in all nine children; the second and fourth died, the former when three weeks old from bronchitis, the latter when nine months old from "dysentery." There had been one miscarriage at the fourth month after birth of the last surviving child, viz., the patient. All the births have been normal and the children breast-fed. The mother has always been healthy, but the father for the last eighteen years has suffered from "fits." There is also a marked history of tubercle on the father's side. The patient is the only girl, and all her brothers have been perfectly healthy; two are now serving in the army.

The patient when three months old had several abscesses on the buttocks which rapidly formed and burst. They were treated with ointment and quickly cleared up. From that time until she was nearly seven years old she was apparently perfectly healthy. Then the left elbow-joint was noticed to be somewhat swollen, and she used to constantly complain of "pins and needles" in her limbs. The mother sought medical advice on account of this. Shortly afterwards the left leg rapidly became deformed, quickly followed by a similar condition in the right leg, so that the child was quite unable to walk. About the same time a small hard lump was noticed in the centre of the forehead, which slowly increased in size, and finally ulcerated through the skin. The child was under medical supervision till shortly before admission to the hospital, and treated for "arthritis."

On admission there was marked anæmia and wasting. In the centre of the forehead was a large ulcer. The photographs give an idea of its size. The base of the ulcer was formed of a yellowish, freely-bleeding slough. The eyes were nearly closed from œdema of the upper lids. There was marked thickening and some forward curvature of the lower two-thirds of the left tibia. The upper two-thirds of the right tibia was equally thickened, but not curved. The lower end of the left humerus and upper ends of the left radius and ulna were definitely enlarged. There was no apparent fluid in the elbow-joint, and movements of this joint were quite free, except that pronation and supination were to some extent limited. There was no complaint of pain or tenderness in any of the limbs. The permanent incisor teeth were half erupted; they were widely separated, almost square, and showed signs of notching. The liver and spleen were both slightly enlarged. The Wassermann reaction was positive.

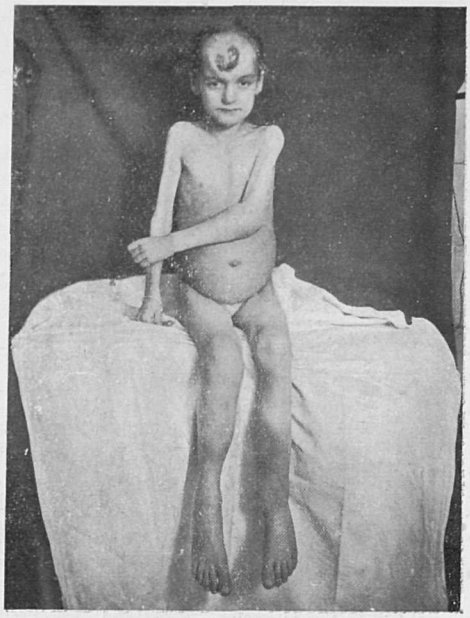
The X-ray photographs show an extensive osteoperiostitis of the right and left tibiæ, left humerus, radius, and ulna. It is peculiar how the disease has attacked the lower part of the left and upper part of the right tibia. The disease of the frontal bone is apparently limited to the outer table.

Since admission the child has been in bed. Mercury has been given in the form of Hyd. c. Creta, gr. i., t.d.s., and a daily inunction of Ung. Hydrarg., dr. ½. The inunction was given every day for six days, a different site of the body being chosen for each application. Then, after a day's interval and a bath, the process was repeated. In addition to this. M. Ferri Iodide has been given, a hydrogen peroxide mouthwash has been used, and sanitas fomentations applied to the forehead. The treatment has been extremely well borne.

In nearly twelve weeks of "specific" treatment there has been a gain in weight of almost a stone, and the patient has changed from a thin, anæmic restless child to a comparatively healthy one. The ulcer on the forehead has rapidly diminished in size, and the base is now a clean, granulating area. Skin-grafting will probably be necessary here. The bony changes since treatment are practically nil, and it is not expected that there will be more than a very slight alteration in them. With the aid of a pair of "surgical boots," the child is now able to walk with some degree of success.

This case resembles many in the late appearance of the disease. The child was nearly seven years old before the first definite signs were manifested. The condition then rapidly developed. A Wassermann reaction has not been done on the mother, but from the clinical evidence available, there is no doubt that the infection was intra-uterine.

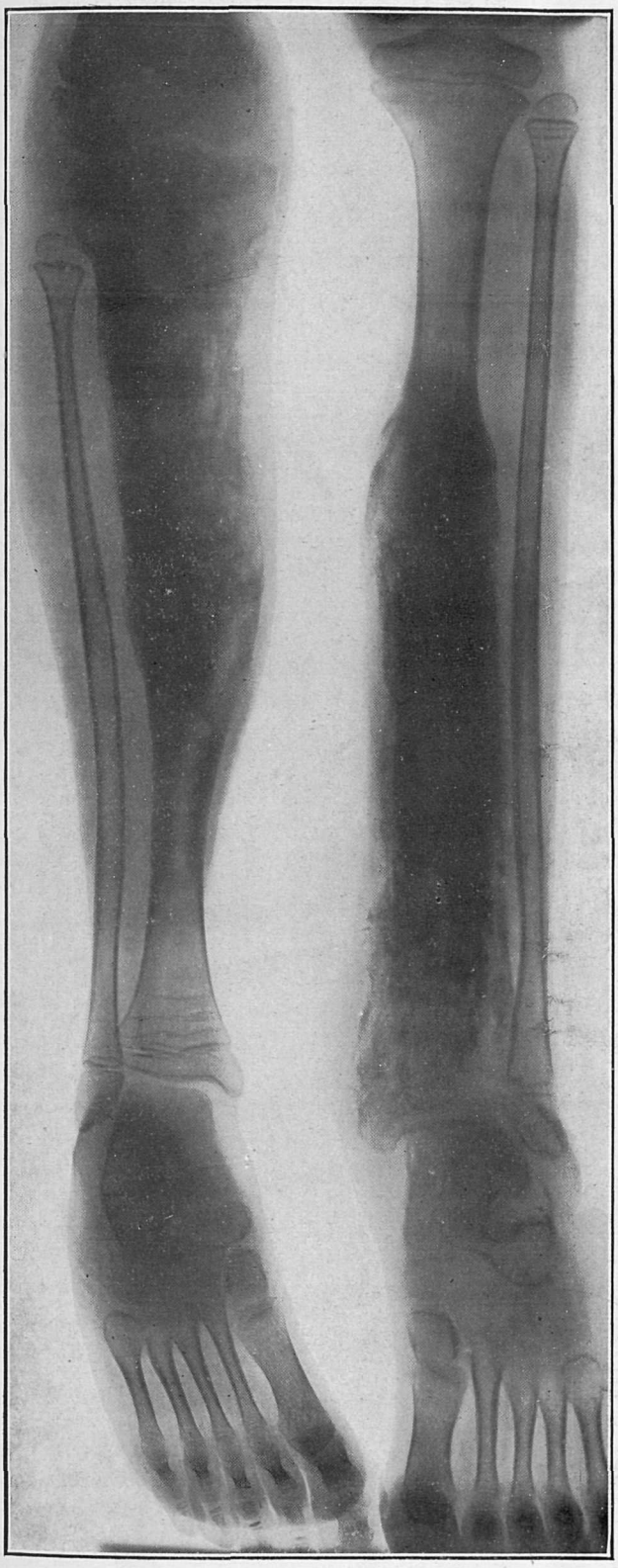
These cases are not very common, but when they do occur it is not unusual for them to be treated for "arthritis" or "rheumatism" for a length of time, until some definite thickening of bone or ulcerative lesion suggests the real cause. In this particular case pain has only been very slight. This is striking, as from the X-rays one would imagine that "bone" pains would be severe. In another similar, but not so advanced a case under my care, the child had severe "bone" pains, resembling that of an osteitis deformans.

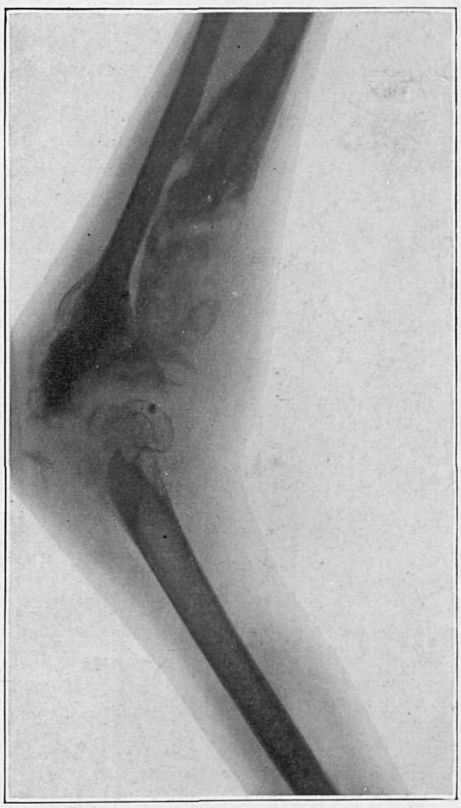


S. C., November, 1914.

S. C., January, 1915.

Photographs illustrating Mr. Saner's Case of Congenital Syphilis.





(For description of Plates see text, page 120.)

The bony changes are usually very little affected by treatment and tend to remain permanently. Sometimes where one tibia is affected, the bone is apparently, and occasionally actually, longer than the normal one. The X-rays show that the outer table of the frontal bone only is affected. There have been no symptoms or signs of intra-cranial syphilis. There was, however, the possibility of it, and on this account, and also that such marked progress was being made under mercury, that the salvarsan has been withheld. The main object of treatment, however, is to arrest the infective process as quickly as possible. The Wassermann reaction is still positive, and as now the general condition is good, salvarsan will probably be of great value.

F. D. SANER.

Guy's Hospital.

Returns for the Bacteriological and Vaccine Department for 1914.

Total number of specimens examined in the Bacteriological Department, classified according to the Department of the Hospital from which each was derived, during the year 1914:—

Medical Wards...	969
Clinical Wards...	603
Surgical Wards	956
Post-mortem Room	129
Out-Patient Department	1,756
Casualty Department—Front Surgery ...	980
Unclassified	1,446
Total, 1914	6,839
Total, 1913	6,681

Total number of specimens examined in the Bacteriological Department during each month of the year 1914:—

January	588
February	632
March	685
April	545
May	790
June	650
July	694
August	455
September	472
October	527
November	402
December	399
Total, 1914	6,839
Total, 1913	6,681

Bacteriological Department.

	1914.	1913.
Complement Fixation Tests	1,078	—
Autogenous Vaccines	462	438

Requests received from the Superintendent's Office to examine Patients in the Wards, 1914:—

January	9
February	23
March	16
April	6
May	9
June	4
July	5
August	7
September	12
October	15
November	14
December	20
Total	140

Salvarsan Apparatus supplied to the Wards and Out-Patients, 1914:—

January	16
February	23
March	30
April	22
May	16
June	40
July	53
August	29
September	19
October	22
November	29
December	16
Total	315

Anti-typhoid Inoculations and Calf-lymph Vaccinations carried out in Evelyn Ward:—

October	10
November	10
December	17
Total	37

Anti-typhoid Inoculations performed on Temporary Surgeons for War, Nurses, Dressers, etc. ... 114

Vaccine In-Patients.—Medical.

	Addison.	Clinical.	Esther.	Isolation.	Mary.	Stephen.	Total 1914.	Total 1913.
Dr. Fawcett ..	1	2	7	—	—	1	11	8
Dr. Pitt	—	—	—	—	—	—	—	11
Dr. Hunt... ...	—	—	1	—	—	—	1	—
Dr. Shaw... ...	1	3	—	—	1	—	5	7
Dr. Cameron ...	—	1	1	—	—	—	2	2
Sir Cooper Perry	—	4	5	—	—	1	10	11
Dr. Hale White...	—	1	—	—	4	—	5	8
Dr. French ...	—	2	—	1	—	1	4	9
Dr. Beddard ...	—	2	2	—	—	2	6	4
Dr. Eyre	—	—	—	—	—	—	31	30
	2	15	16	1	5	5	75	90

Vaccine In-Patients.—Surgical.

	Astley Cooper.	Charity.	Cornelius.	Dorcas.	Eye.	Job.	Lazarus	Luke.	Lydia.	Martha.	Naaman.	Pat. and Sam.	Queen Victoria.	Total 1914.	Total 1913.
Mr. Hughes	1		1									4		5	7
Mr. Thompson	1				5									1	2
Mr. Mollison		2										4		5	3
Mr. Turner												5		6	5
Mr. Fagge							2					3		7	7
Mr. B. Smith	1					4			2				6	9	3
Mr. Steward												6	7	7	14
Mr. Rowlands					5									6	3
Mr. Eason	1			5							2	1		5	1
Mr. Dunn								4		1			7	9	18
Mr. Chapple		8			1		1						7	13	6
Sir A. Fripp	=													1	5
Sir A. Lane														1	10
Mr. Ormond												1		1	1
Mr. D. Colley														—	4
Mr. Saner														1	—
	3	10	1	5	11	4	3	4	2	1	2	24	13	83	89

Vaccine Out-Patients.

Month.	No. of Letters issued.	No. of Attendances.	No. of Doses administered.	
			Tuberculin	Vaccine.
January ...	125	241	66	96
February...	59	237	44	114
March ...	39	250	43	114
April ...	30	204	45	87
May ...	33	214	62	116
June ...	33	221	39	120
July ...	53	268	48	125
August ...	25	181	40	108
September	22	191	36	104
October ...	21	227	46	87
November	13	173	42	86
December	15	166	45	76
Total 1914	468	2,573	556	1,233
Total 1913	424	2,706	733	1,180
Total 1912	307	2,273	656	1,070
Total 1911	314	2,343	848	990
Total 1910	234	2,145	1,030	671

Letters from Men on Active Service.

H.M.S. ——

Dear Mr. Editor,

Unless sent from such ships as H.M.S. *Lion*, it is not unreasonable to suppose that letters from the sea cannot be of such interest as those from the front. But a naval surgeon may be placed in some very quaint positions, and perhaps their peculiarity justifies their description.

The writer has for some time held the post of surgeon on a so-called examination vessel, which vessel is comparatively small and patrols in the neighbourhood of a harbour, while its officers board and examine all ingoing ships. A surgeon is carried because a large number of destroyers and torpedo-boats are always with the examination vessel; moreover, there is the possibility of an encounter with the enemy ships.

The surgeon lives with the Commander, and since they have the advantage of each other's society, day in and day out, without the intervention of a third person, it is most desirable that they should have some tastes in common. The writer was fortunate enough to have much in common with his Commander, and not the least conspicuous of their intellectual tastes were sausages and chess. Sausages were considered by both a very sustaining form of diet, and, although a sausage is always an article of speculation, yet, perhaps, not so much so as some of the suety compositions of the ship's cook. Chess passed several evenings when all was quiet and there was not much else to do, the silence of the night being only broken by occasional loud cries of "jai daubé."

Anyone who has been kind enough to read so far will probably ask, "What of matters medical?" A destroyer approaches at the end of a stormy day, cutting through the water at a rapid rate, the spray dashing over her bows. When within hailing distance she slackens speed, and a hoarse voice is heard through a megaphone, "Is there a doctor aboard?" "Oh, yes, there's a doctor aboard alright; very much aboard, in fact, and wishes he could say the same for his most recent meal." "Would he please come aboard and see a sick man?"

A boisterous passage is made in a small rowing boat, and the doctor is helped aboard by two lusty arms. Going down one of the after hatches, he arrives at the Petty Officers' quarters, where bedroom, sitting-room, etc., are crowded into what might be adequately described as no room room at all. A large man is found lying in his bunk, and between the rolls of the ship a diagnosis of influenza is made. Since the patient is feeling very ill, arrangements are made for his transference ashore on the next day.

Before the doctor came aboard, the sick man's messmate had been somewhat exercised in his mind at the sudden cessation of the robust health of his friend, and, in order to have some idea of the severity of his condition, had resorted to a thermometer for information. He had not the clinical variety aboard, but had, by reason of his great persuasive powers, eventually induced the sick man to place in his capacious mouth. case and all, a thermometer which, when discharging its normal functions, hangs on the wall to record the temperature of the room. The patient did not seem much the worse for these drastic measures.

On another occasion a sailor had his scalp badly burned. While he was asleep in his bunk on a rough night a bottle of caustic potash upset and the contents dripped on his head. He stated that at first he was conscious of a tickling sensation, but probably was not much disturbed by this, since it is generally recognised that there are often other things on board ship beside caustic potash that cause a tickling sensation. When he did wake he naturally found his head badly burned. That's the light side—but it's not all light.

Boarding vessels in fine weather is no hardship at all, but when the weather is rough it is decidedly the reverse. It is not an uncommon thing for officers to get their legs badly squeezed between two vessels. One case occurred where one poor chap fell overboard and was so badly crushed that he died. Another, who fell overboard was more fortunate; every time he was about to rise to the surface, and be jammed between the two ships, he was pushed under by a large fender hanging over the side. When the vessels fortunately parted slightly he was pulled aboard by a boat-hook, and, although half drowned, recovered.

There is one great pull that a sailor has over a soldier: however arduous his duties may be and however much he may be exposed in carrying them out, he always has a dry and warm place in which to sleep.

Well, it is now time to turn in; the process of going to bed is unknown in the navy.

E. R. BAILEY.

Hôpital de l'Espérance,
Les Terrasses,
Tréport, France.

Sorry not to have written you and told you all about our blessés. We have been very busy and I have not written more than the one letter home for the last six weeks—that, by the way, is never started until about midnight.

We have been receiving nothing but severe cases lately, and for the last three weeks have had an average of one operation a day. Eyes out, legs off, arms off, etc. I have three amputated legs amongst my dressings now, an amputated arm, suppurating fractures of all kinds, and numerous lacerated shell and explosive bullet wounds. We have also interpolated two hernias and two appendicitis'. For the last three weeks I have had a septic thumb, and this has prevented me from dressing at any of the operations, and has at the same time landed me in for all the anæsthetic business.

The University are letting me take the 2nd M.B. in Chemistry in March as an External Student, so I want someone to relieve me here—do you know of anyone who would take the job on? Lady Gladstone will be in charge from next Monday, as Lady Murray is going home for a month. I should like to be relieved immediately. Will you let me know if any of our men would care to come? It is useful work and at the same time a glorious holiday, one's afternoons are free, and the sea and country are splendid.

12 p.m.—Have just been called off to give a man an anæsthetic who has secondary hæmorrhage due to sepsis—the arteries are now tied, I hope he will get through the night without another go.

Morning.—No. 42 alright—no more hæmorrhage, poor fellow, he has both hands off and one leg at the thigh, and yet goes under the anæsthetic calling out Vive la France. Adieu! Yonrs sincerely,

Feb. 19th, 1915. R. W. WARRICK.

Change of Address.

Lieut. S. W. Coffin, R.A.M.C., Officers' Quarters, Netley, Hants.

G. W. Holloway, H.M.S. *Impregnable*, Devonport.

Lieut. R. C. Matson, R.A M.C., 71st Field Ambulance, Tweseldown Camp, Farnham, Surrey.

Lieut. N. H. W. Saw, R.A.M.C., 71st Field Ambulance, Farnham.

Capt. C. H. Reinhold, I.M.S., c/o Messrs. Grindlay nd Co., 54, Parliament Street, S.W.

L. Horsley, 81, London Road, W. Croydon.

Prob. Surg. N. Barlow, R.N.V.R., H.M.S. *Murray*, c/o G.P.O.

Fleet Surg. W. Bett, M.V.O., R N., H.M.S. *Benbow*, c/o G.P.O.

Lieut. B. R. Parmiter, R.A.M.C , to 15th General Hospital, British Expeditionary Force.

(*The Editor will be very glad to receive a post card with notes of any change of address.*)

Books, etc., Received.—The St. Bartholomew's Hospital Journal, The Hospital, The New York State Journal of Medicine, The Nursing Times, The Magazine of the Royal Free Hospital, The Prescriber, The St. Thomas's Hospital Gazette.

Chronic Abscess of Bone, and its Treatment

CLINICAL LECTURES
BY
MR. CHARTERS SYMONDS, M.S., F.R.C.S.,
Consulting Surgeon to the Hospital.

LECTURE II.

GENTLEMEN,—In my first lecture I hope I convinced some of you that there is a form of central osteitis, septic in origin, and part of a general infection. I brought forward cases to show that what were hitherto thought to be tuberculous conditions were, some of them at least, due to the ordinary streptococcal or staphylococcal infection, and, indeed, I take it that some of them may be pneumococcal, or even influenzal in origin. I called your attention to some of the most remarkable points about them, especially their duration, and mentioned one instance in which the abscess had been forming for thirty years, and another in which it had been forming eighteen years.

There are two remaining points to be discussed to-day. The first is with regard to the symptoms. You will find it generally stated that the pain in these cases is severe, in fact, many of the older writers described it as being excessive in severity and accompanied by much tenderness. In the patient in whom the disease lasted thirty years you may remember that she was able to walk about, and only for a few weeks before coming into the hospital was the pain sufficient to lead her to apply for treatment, although she acknowledged that for ten years she had had "rheumatic" pains. The other, a boy æt. 17, had had sufficient pain to keep him awake at night, but it was never excessive, although it sufficed to prevent his enjoyment of games. Some of the patients had periods of greater pain, coming on especially at night, and all had tenderness. And I brought forward this specimen, No. 4237, which I show you again, as I hope to claim it as an example of central septic osteitis, and not tuberculous in character, as it is labelled. It shows you, as I pointed out in the last lecture, how the inflammation reaches the surface and determines the formation of tender bony nodules. When filled with bismuth paste, the size and ramifications of the cavity can be estimated, as, for example, in this tuberculous cavity in the shaft of the tibia.

The next point which I wish to specially pay attention to to-day is the treatment of these cases. Sir Benjamin Brodie, who first advocated the employment of a trephine in 1832, while he described the opening of the abscess successfully, gives no account of the after-treatment. Nor do the books give very much account of the after-treatment, so that one would be led to the conclusion that, once they were trephined, the after-course was a comparatively simple matter.

The usual treatment after evacuation of the pus is to plug with gauze, and that was the treatment which one adopted in the earlier cases. On watching cases so treated, one found it was impossible to keep them at all clean. They became septic, and there always followed a very irritating septic dermatitis round the wound, leading to an eczematous condition, attended with much pain and distress and requiring frequent admission to hospital. It was a very unsatisfactory method.

The second plan of drainage, by means of rubber tubing, is not much more satisfactory, for a rubber tube promotes the formation of granulations, and, moreover, the bone forming round the orifice of these cavities compresses the rubber, so that when removed for cleaning it becomes difficult to replace, consequently it is left out, either by the medical man in charge of the case or by the patient. Then septic infection takes place in the cavity, and the whole series of events begins over again.

Now, there is a third method, namely, to chisel away the surrounding bone and bring the bottom of the cavity to the surface. Where available it is an excellent plan, and I have carried it out with success. But when the cavity is in the centre of the bone, or, as in the case where we found the pus close to the articular surface, it would be impossible to adopt this method. It has, therefore, only a limited application.

There is another method, which is ideal if we could carry it out; to open the cavity, evacuate the pus, sterilise the cavity, and fill it with absorbable antiseptic material, very much in the same way as a dental surgeon fills the cavity of a tooth. This method has been carried out by one particular surgeon, Moestig, who, after cleaning the cavity, sterilizes it with hot air, and fills it with a mixture of spermaceti, iodoform, and oil, and claims many successes. It is so difficult to render these cavities aseptic that most of us will have to adopt some method of drainage.

PLATE IV.

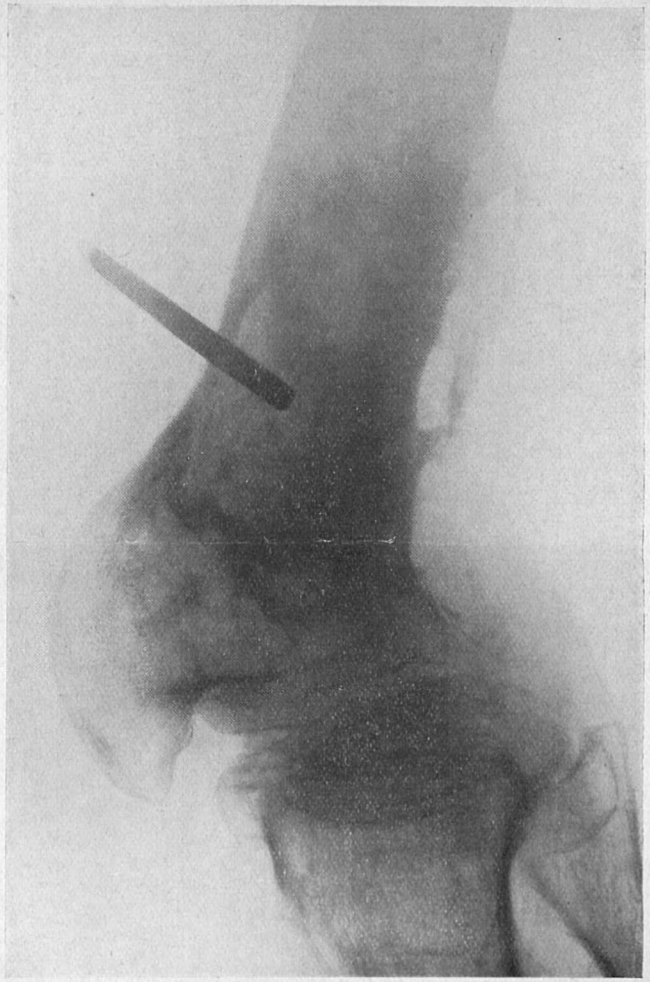


PLATE V.

Plates illustrating Mr. Charters Symonds' Clinical Lecture on "Chronic Abscess of Bone, and its Treatment."

It was the unsatisfactory results of the after-treatment of these cases which led to the employment of metal drains which have, in my hands at all events, solved the difficulty.

In the process of recovery two things have to take place: the cavity must be obliterated, and the whole of the new material causing enlargement must be absorbed. The two processes take place together, and very slowly. The extension of the abscess and the thickening of the bone are due to septic changes in the cavity, which are best got rid of by free drainage. And the drainage must be secured by employing a material which will prevent closure of the opening by resisting the pressure exerted by the bony growth, and the material must be durable, easily sterilisable, and the drain painlessly removed and introduced by the patient. Metal fulfils all these conditions; it resists the pressure of the growing bone at the margins; it is unirritating, and it is a notable point that in cases where a metal drain has replaced a rubber the troublesome granulations disappear. This effect can be compared with that of a tracheotomy wound, which remains free from granulations so long as a silver tube be used. And in these cases which we are considering, the tube can be managed by the patient, is easily taken out, boiled, and replaced.

Another point of great importance is that the drain enables the patient to go about his work, for the dermatitis surrounding the orifice disappears. A lady under my care with an abscess in the lower end of the tibia wore one of these drains for two years, and was not laid up during the whole of that time. The woman from whom this skiagram was taken (see Lecture I., Plate I.) walked to and from her work while wearing a tube in the lower end of the tibia for the best part of two years. And there was also the case of the man I mentioned last time who carried a tube in his tibia while driving a motor omnibus. The woman whose skiagrams are now exhibited to you has been wearing a tube for eight years. The second one she has worn since 1910. So by means of these tubes we get rid of a prolonged invalidism.

As to the form of the drain, here are examples which have been used in various patients: some are channelled, others solid. If it be a hollow tube and large, it is important, when introducing it, to have a pilot of metal or boxwood to prevent injury to the granulations lining the track and consequent pain.

Painless introduction is of the first importance, if the management is to be left to the patient, otherwise he will leave it out. Therefore, all channelled drains should be drawn slightly over at the end, the orifice being smaller than the diameter. This forms a more serviceable tube than one with a pilot.

The other drains are solid. At first you may think these would not be effective, but long experience shows that they answer just as well as the tube, for moderate-sized cavities, and especially for the later stages when the track is narrow. The solid metal drain is easy to keep clean and to introduce. You will notice it has a nail head, and is made of silver or aluminium. One or two are of flexible metal to permit of adaptation to some devious track. And notice that in two a bulb has been added with a view of preventing its being extruded. These were made for a case to be mentioned later, in which the femur was affected and prolonged drainage necessary. The drain came out when he played tennis or took other exercise. The mechanism was quite effective, and did not interfere with drainage. In the early stages of treatment, and for some weeks where the cavities are large, the tube with a pilot must be used.

To determine the length and diameter of the drain, in the first instance, a piece of rubber tubing long enough to reach to the bottom of the cavity and as wide as the channel cut through the bone is taken as a pattern. This is sent to the instrument maker, or local silversmith with directions to make a silver or aluminium tube of similar dimensions, but with a thin wall, and carrying a flange at the outer end. This flange facilitates removal and prevents the tube sinking into the wound. A piece of rubber tube of similar dimensions is inserted temporarily.

Silver is the best material for tubes as it can be readily soldered and is light, but it is expensive. Aluminium does quite well for solid drains, but is not so suitable for large tubes. No solder has been yet discovered for this metal, so the flange must be rivetted, and is liable to separate, as you will see has happened in one example. Anyone can make a solid drain out of a piece of aluminium or silver wire; the point is that a small solid metal drain is more effective than a larger rubber one, and gives no trouble. I showed you a woman who has been wearing a piece of silver wire for three or four years, and one of the small tubes shown here was worn for ten years.

How shall you know when the tube should be removed? You must measure the size of the cavity by removing the tube, bending the point of a probe to a hook, and passing it along the canal; you can tell whether at the bottom of it there is an opening or cavity. If there is no cavity, a smaller tube can be used. If the moulding of the bone has become nearly normal the tube may be removed, but it is better to gradually reduce the size of the drain until you come down to a piece of wire.

The duration of drainage depends upon the size and character of the abscess cavity, the density of the surrounding bone, and the time a sinus has existed, if there be one. In young people recovery is rapid, the lad of 17, for instance, with a small abscess in the tibia, wore a small wire drain for eight months, another of 19 with a large cavity in the femur was well in a year. On the other hand, in the old cases with several centres, or with a long-standing sinus and septic osteitis, a drain may have to be worn for years or for life. The tendency with most is to remove the drain too soon, and, considering that no interference with the patient's activity or power of work results, whatever bone be affected, it is better to wear it too long than incur the risk of recurrence.

I am especially interested just now in the value of metal drains in gunshot wounds through the carpus or the tarsus, where the bones are very much broken up, as you see by this skiagram of an officer's hand (Plate IV.) The bullet went across, below the ulna, and broke the lower end of the radius. Like all these wounds, it was very foul, there was enormous swelling of the hand, and he was told it might have to be amputated. But there being no general infection, he was treated by irrigation. In the fourth week the wound was lightly curetted, and a rod of aluminium passed across so as to project from each side. Later the drain was reduced in size and length, as you see in this skiagram. The improvement has been rapid and the drainage effective. Let me add that while under ether, the arm, forearm, and hand were put up in a plaster of Paris splint with immense benefit, and dressings made at first daily, and then in two or three days.

I will conclude by referring to another variety of central osteitis. We have seen examples of chronic septic osteo-myelitis, acute in origin, due to the deposit of bacilli in the course of a general infection. Following their early death, the remains of the bacilli act as an irritant to the bone, leading to the general formation of pus and a thickening of bone due to a deposit on its surface. You are acquainted with acute osteo-myelitis, that very grave disease in young people following upon slight injury, which determines the escape of bacilli into the tissues, with rapid extension and suppuration, so that within three days from the moment of the first symptom the patient is desperately ill. That is one extreme of this form of disease. The other extreme is the one I have been relating to you. Between these pathological extremes there must be intermediate degrees, which we may call subacute central osteitis, to which I will now call your attention. The infection is milder, spreads slowly, the bacilli remaining alive and continuing to produce pus. A typical example was that of a young midshipman of 18, who complained for some days in July of pain in the lower end of his femur. An abscess formed, with which he continued to walk about; later it was opened, and a diagnosis of periostitis was made. He got so well that by August the wound had closed and he was able to get about freely, even to dance. In September pus slowly re-formed; it was let out, and a bare bone found. No exploration further than the surface was made. That was in September, 1891. In February, 1892, he came to England with a sinus in the lower third of the thigh, considerable enlargement of bone, and a stiff knee. He was brought to me to answer three questions: What was the cause of the disease? He had been told it was tubercle. What were his chances of getting well, so that he could re-enter the Navy? He had been told he would probably never be able to resume his service. And, thirdly, what was the best treatment? On the diagnosis of tubercle there was no prospect of recovery in a reasonable time. I took the view that there had been a subacute infection of a single bone, part of a general infection which had given rise to nothing more than headache and some malaise, that he would, if efficiently treated, recover the use of the limb and knee and be able to resume his duties. On opening the sinus a considerable cavity was found in the interior of the bone. This was drained by a large metal tube, and after a little time he went away. His knee was rather stiff when he came, and he was encouraged to use it. Being very energetic and keen to get back—he was only 19—he carried out all my instructions, and perhaps even exceeded them somewhat, with the result that in twelve months he was back in the Service, and shortly became

the youngest Commander in the Navy. He came to see me 16 years afterwards, and I found he had a perfectly normal knee, and there was hardly any difference between the two femora.

The other man was a cavalry officer 32 years of age. While serving in India he complained of pain in the lower third of his thigh, thought to be rheumatic. A swelling formed slowly in this position, an abscess was opened, and the condition was set down as periostitis. That was in November. He was sent home to England with a knee which he could hardly move, and with a sinus in the lower third of the femur. On examination, a probe entered the cavity of the bone, and, looking upon it as a sub-acute septic infection, I opened the bone freely and put in a large tube. He was told to walk on it as soon as he could, and in about a month he was doing so pretty freely. That was in March, 1907. A year after this operation he could do everything: he could bend his knee to the full extent, and was playing golf. Having a sinus, he would not be passed by a Medical Board, and so he had to remain in England. He was so well in July that the medical man who saw him in the country said, "You are well; there is no necessity for you to wear this tube any longer, we will take it out." But he came to grief, for septic infection took place, and he had a very large abscess, and I had to put a tube in again. As there was difficulty in retaining the drain, a bulb was added to prevent its being thrust out by the action of the muscles. You might think the bulb on a solid drain would lock up the pus and determine an increase of the sepsis, but in practice this is not so, the pus coming away by the side. Two years and seven months from the operation he was able to return to his regiment in India still wearing the solid drain; he was able to ride and to carry out all his duties. He came back in 1910, a year afterwards; the drain, now no more than a thick piece of silver wire, was removed, and he remained well. I do not know any other method by which patients can carry on their activities as did these men. I was sorry to see that this officer fell in the War a few days ago.

It is possible for this same sub-acute variety to occur in early life. You will remember the old lady I showed you last week, Mrs. M.; she is 70, and came in six years ago with a swollen knee-joint, and a diagnosis of long-existing tuberculosis of the femur, with secondary infection of the joint, prepared for amputation through the thigh. Her history showed that at 15 years of age she had a slowly-forming abscess in the lower end of the femur, but only moderate pain with it, as she could walk about. This was opened, and for nine years the sinus gave no trouble. She was now 24 years of age, and her troubles began. Septic changes took place in the cavity, and she became subject to short illnesses, with pyrexia, swelling of the knee, and much pain. This kind of thing went on for about forty years. During these years the knee-joint gradually became more and more stiff, and when she came into Guy's at 64 years of age the knee was swollen, the articular margins irregular, and a large cavity existed in the centre of the femur. Recognising the condition as not tuberculous, instead of amputating we opened up, and found a cavity in the centre of the bone having dense, irregular walls and many pockets, and put in a large drainage tube. It was extraordinary how rapidly she improved; the septic trouble disappeared, the mobility of the joint increased, and she went home able to resume her charing, which she still continues to do. Mr. Shenton was good enough to make some skiagrams last week, and you can see from them what happens in these cases when they are left alone. From time to time the patients get attacks of septic infection in the joint followed by increasing lameness due to changes in ligaments and bones. The radiograph (Plate V.) shows the irregularity of the bone, the lipping along the margins, and the ankylosis of the patella to the femur. You can also see a central cavity. The enlargement has subsided a good deal, and, though lame, she is able to get about in moderate comfort.

When you saw this old lady last week, she was in a bad general state; she had been laid up in bed and could not look after her tube, and there was some dermatitis; but on the previous occasions when I saw her there was no skin infection, and as long as the tube is kept clean she is comfortable. I think she will have to wear a tube as long as she lives, for, on account of her age and the density of the bone, complete absorption may not occur. Another case I wish to mention was that of a man who ought to have known better. Being an architect, he wanted to design his own tube, but I convinced him that in this matter I probably knew better than he did. After considerable trouble he permitted me to operate and insert a tube in an old thick-walled cavity in the lower end of the femur. He was doing extremely

well; the knee subsided; he had been anæmic from attacks of septic absorption, and his anæmia disappeared, and he became better; and his brain power was better. But the tube was taken out by his own medical man, and he relapsed. I persuaded him to let me put it in a second time. It was in 1905 that I saw him first. I inquired last week how he was, and was told that he is a chronic invalid suffering from hemiplegia. How far that may be due to the degenerative effect of constant attacks of sepsis from 14 years of age I cannot say, but since the tube was left out he has had the old attacks of fever with absorption. Better to have had his leg amputated.

These, then, are some of the cases which I wished to bring before you as illustrating a rather difficult subject in treatment. In the tuberculous cases I have only to say that the same method is applicable, though in these it is better to fill the cavity with bismuth (paste), especially in young children. In the older cases I do not think bismuth is so good. I hope you understand that the older the patient is, the longer the drainage should be continued; when they are young they get better pretty quickly.

I hope I have made it clear to you that while these cases are acute in origin they run a subacute or chronic course, and that they may all be explained on the same lines, namely, as due to a deposit of infective material in the early stages of a general disease.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Practical Sanitary Science. By David Sommerville, M.D., M.Sc., D P.H. Demy 8vo., viii.+328. Price 10s. 6d.

The second edition of Professor Sommerville's book will be received in the Public Health world with great satisfaction. We give our unstinted praise for the arrangement of the subject-matter, for the lucid descriptions of the various operations, and for the illustrations which take the form of photographic reproductions. The introduction of some physics in the chapter on air is commendable, since this subject is of considerable importance in the curriculum for the Diploma.

We congratulate the author on his book, and feel sure that the Public Health worker and student will find it a valuable help.

Work in the French Red Cross.

LATE in November Sawday and self applied for posts as dressers with the French Red Cross. We were duly examined for fitness, and after a delay of ten days were appointed to an Anglo-French Hospital just about to commence work at Le Treport, a small port and summer resort about 20 miles N.W. of Dieppe. The hospital, a new golf hotel of 65 beds with hot and cold water laid on in every room, was instituted and ably directed by Lady Murray. During the absence of the latter in England it is now being carried on by Lady Gladstone. The staff consists of a surgeon, assisted by two dressers, six nurses, and seven French nursing orderlies. A different surgeon takes over the work every month. W. E. Hills, a contemporary of Messrs. Fagge and Rowlands, was the first, followed by H. W. Carson, senior surgeon at the Prince of Wales, and afterwards by H. D. Gillies, of Bart.'s.

With only one surgeon plenty of work devolves on the dressers—all the anæsthetics (there is, on the average, one operation a day), lesser operations, occasional inoculations, and the dispensary. Dressings keep one busy for at least six hours of the day; they usually involve irrigation with hydrogen peroxide and application of H.B.F.'s, occasional iodine baths, and, rarely, a dry sterile dressing.

Wounded, newly arrived, are first stripped and washed or, if their condition allows, tubbed. A bath is quite a new experience to most of them and, for the matter of that, so is a bed to some of the Zouaves and Turcos. One man absolutely refused to sleep in a bed; I suppose he thought it too dangerous.

The fifty-mile journey from the front takes, on the average, two days, and by that time all the wounds are septic in spite of a liberal use of iodine or iodoform. A large proportion of the wounded have severe compound fractures of either humerus or femur; amputation is often necessary with the latter, rarely with the former (5 to 1).

The French make cheerful patients, bear pain well, and all are very grateful for anything you can do to relieve them. Most have been wounded before, and so can appreciate the advantages of treatment in an English hospital. Rapid improvement is the general rule; there has only been one death during the past three months, and that secondary hæmorrhage from a hopeless abdominal wound.

Three months spent in this way is excellent experience. I should recommend anyone taking up similar work to do a little nursing in the wards; the few tips I gleaned from Sister Naaman in the summer vac. were invaluable.

R. W. WARRICK.

With the Northamptons.

The 1st Battalion of the Northamptonshire Regiment (48th Foot) was one of the first to go to France, and went through all the phases of the war—Mons, Marne, Aisne, and Yprès—and it is only necessary to read Sir John French's dispatches to know that they fully upheld their reputation in all.

It was during the well-earned rest after Yprès that I joined the battalion. We left Southampton with a draft on the 23rd November, and, after lying one night in the Solent, crossed during the night of the 24th to Havre. The crossing was quite pleasant (in spite of the fact that we found ourselves in cabin No. 13), and the ship's doctor, being a bridge enthusiast, assisted us to pass our evenings deep in "auction."

At Havre, the next move was to the base camp on the hills south of the town, and here we spent the next few days putting the final touches to equipment and generally preparing to go up country. In our ignorance we grumbled at the camp being muddy, although nowhere was it more than six inches deep. Notwithstanding this we managed to be fairly comfortable, as we had our valises, and tent boards kept the worst of the wet away, though they cause one to wake up in the morning with a very sore hip.

A bright spot in those few days was an evening's leave, most of which we spent in having dinner at the Tortoni; it is surprising what an excellent dinner one gets in a French hotel at the cost of a few francs.

At mid-day on the 28th we entrained, and after a somewhat wearisome journey, during which the train travelled by a series of short dashes and long pauses, arrived in a small town, "somewhere in N.E. France," where, having discovered the mess situated in a "corsetière," we obtained a more or less respectable meal. Our home for the next three weeks was the sometime residence of an abbé who, apparently, had vanished on the outbreak of war. Although the house was fairly well furnished and simply abounded with patent medicines and religious emblems, we were quite unable to find any washing apparatus, and had, perforce, to make use of various dishes and the larger saucepans for our ablutions. A footbath discovered in the cellar became very popular, in fact it was generally necessary to book it in advance if required for any particular hour.

Our time was spent in usual drill, etc., punctuated with field-days and marching, whilst in spare moments after the day's work one met congenial souls in the local cafés or "pattisseries," where the time passed quickly over café-kümmel, varied with an occasional game of "pills." Auction provided a means of spending the evenings, in spite of the fact that we were handicapped by scarcity of cards, as the French piquet pack contains 32 only, and were the only ones procurable; however, an amalgamation of two packs of similar design provided us with a usable, but somewhat obscure set of 52; indeed, it was necessary to carefully explain to a new comer that he must not be sure he had an ace of hearts till he had thoroughly examined it to see that it was not marked as the two of that suit.

On the 6th, and again on the 20th, December we had visits from German aeroplanes; on the former occasion several bombs were dropped, but on the latter the 'plane was promptly attacked and driven off, pursued by one of our own machines before it had time to get busy. It was on the latter date that we received orders to "stand by," and on the morning of the 21st the battalion was embarked on motor 'buses and carried off towards the trenches. Most of these 'buses had their names, christened by previous passengers; personally, I travelled in one named "Tottenham Hotspur," whilst the neighbouring ones were "Aston Villa" and "London Cabman's Home," and others had equally appropriate titles.

We went out that night to make an attack on a line of trenches temporarily captured by the enemy. We had to advance over very heavy ground, even before we got to the position of deployment, and I remember feeling very sorry for the battalion cyclists struggling hard to get their mud-clogged machines along.

We took the trenches in due course, the enemy very obligingly leaving them before we arrived, and started to render them suitable for our own habitation, that is to say, building up a parapet on the front side and removing sundry dead bodies, etc., which had accumulated. That night was spent, as may be imagined, with a marked absence of sleep, and we were not sorry when we received orders to hand over to another regiment and retire. At about 9 a.m. on the 22nd we had our first meal since breakfast at 6 a.m. the previous day. Hardly had we finished when orders came to be up and doing, as the Germans were attacking; so out once more. This time we went into a *fairly* dry ditch in support of the main line, but as during the day our first line repulsed the attacks, we had no further trials. It was very cold, however, snowing and raining alternately, and though we built ourselves a "booby hutch" of branches and straw which kept the worst off, one's feet soon became, and remained, painfully cold. It was very difficult to get any sleep that night, due to the fact that one of our batteries, about 200 yards behind us, fired "salvos" at intervals during the night, which, besides making noise enough to wake the dead, generally brought a few coal-boxes in return.

On the 23rd came the welcome news that we were to be relieved, and about 12 p.m. we arrived in a little one-horse village in the rear with quite a sporting chance of having Christmas under a roof. As,

however, it seemed very probable that we might have to move on the 25th, we celebrated our dinner on the Thursday. Bully stew and "Machonachie" formed the main theme, whilst ration plum pudding, supplemented by the contents of parcels from home, formed the seasonable element. In default of brandy, rum made an excellent substitute for burning on the puddings, the latter proceeding being intensely interesting to the good people of the house; indeed, the whole family regarded it as some weird rite, but were very pleased when we asked them to share with us, and that, together with the present of a tin of ration "confiture," put us well in their good books.

As luck had it, we had Christmas day in quiet, and, of course, had to beat up all supplies to celebrate another dinner. Very fortunately two parcels, containing puddings, etc., came in the morning, so we were able to have our dinner on the same lines as before, though, on this occasion, we had obtained two bottles of "Scotch," the fruits of a 6 mile ride.

Our French hosts, very pleasant village folk, celebrated Christmas by dressing in their "Sunday-go-to-meetings," looking very stiff and uncomfortable all day, until in the evening they got back once more into their dirty, but comfortable, corduroys. The happiest member of that family was a little girl of about three. During our entire stay she wore a smile, and would sit for hours in a special little chair of hers, with her feet on a hot brick, which was always kept in the stove for her, singing little songs and playing with the funniest firewood doll you ever saw.

Boxing-day found us en route for the trenches, and when we arrived at our destination we received the encouraging news that we had to go up in sections at 100 yards interval. "In case, you know, the Germans open on you with shrapnel as they have been doing here lately!" A nice reception! However, we arrived without casualties, half the battalion going into the firing line and half in support.

It was in the fire trenches here, on the 29th, that I had my first introduction to the "minenweter," or trench mortar, employed by the Germans. This throws, or rather lobs, a big shell up into the air from their trench to yours. It makes no sound, but is perfectly visible and can, with luck, be dodged. It is known to the Tommy variously as the "Lobster" or the "Rubber heel" for the same reasons.

About six of us had fore-gathered just after breakfast in a "dug-out," when we were suddenly startled by an appalling crash. A servant outside announced the cause, and almost immediately cried out, "Here's another coming right down here." There was a general dive for the deeper corners of the dug-out and a nasty moment or two of suspense. It fell fairly close, and we then split up by mutual consent with some celerity. These "Lobsters" make a lot of noise, and are not at all nice, but, although I have seen about sixty, I do not know of more than half a dozen casualties caused by them. It is most surprising how close they can come without doing any damage.

On the 31st our support trenches earned the name of "Coal-box Villa," due to the fact that about midday the Germans would drop coal-boxes round them. On one occasion they got the range so nicely that had not everybody rapidly evacuated the neighbourhood there would, no doubt, have been many casualties; as it was they only succeeded in completely digging up one poor fellow who had been buried the day before. My platoon sergeant, a priceless fellow, sat in the entrance of my dug-out and announced the coming of each one; if it seemed to be coming close he would tumble back into the dug-out, whilst a "Well away, sir," merely called for a partial retreat to cover.

There seems to be a subtle ability acquired by those who have been under much shell fire to not only immediately detect the type of shell, but also tell roughly the direction it is taking from the bang and shriek previous to the burst; indeed, I acquired to some small extent the "ear" to separate all the different "cries" from the slow gurgle of "Creeping Jesus" to the shrill whistle of "Little Willie."

New Year's Day found us in the firing line again, and, owing to the very wet weather, most of our time was spent building up and draining the trenches. We also finished the construction of a somewhat palatial dug-out. The next day we were relieved, and, very tired and dirty, returned to some "billets" where, with straw for a bed, we spent a fairly good night. One disadvantage of this particular billet was its situation between two of our batteries, which position was consequently about right to catch odd shells aimed at them; fortunately none actually hit the place during our period of residence.

On the night of the 4th we were ordered back to the trenches again. It was one of the darkest nights I remember, quite impossible to see the man next you. We went up in single file, holding each others pack straps, etc. On our way we had to go through 500 yards of communication trench which, we had been warned, was knee-deep in water. We found the first part "fairly dry," it only being up to the calves, and an N.C.O. in front of me was just congratulating himself that it was not so very bad, when splash! in he went up to his thighs, much to the general amusement, but we all had to go through that part.

The next week was the hardest we spent: bad weather and the continual strain of living in first line trenches, together with the fact that all the dug-outs were falling in owing to the soft state of the earth, made it an orgie of slush, blood, and cold. It was quite impossible to keep warm at night time; always wet to the knees and exposed to bitter winds

the men stuck that week with marvellous fortitude; so long as they could get a chance of making a canteen of "Hot and Dirty," as tea is known out there, they would carry on almost indefinitely. I should have liked to have had some of the "stop-the-rum-ration" fanatics up with us that week!

We had had a good laugh at the men we relieved at their generally filthy and weary look, but I am afraid we were far worse than they had been when we finally went back on the 11th. The 500 yd. communication trench was considerably deeper than before, and to add to our difficulties some telephone wires had been washed out of the bank and formed a series of "snags" which necessitated very slow progress, but the joy of going in front of a decent fire and getting a shave and wash when we finally got to our billets almost compensated for it.

The next day or two was spent in billets, gradually getting ourselves as clean and respectable as possible, issuing new clothes and boots, etc., and getting rifles well cleaned and oiled. One day I had an afternoon leave during which I cycled to a neighbouring town to get some supplies for the company mess. Coming home on a pitch-dark night with no lamp was quite exciting, but was accomplished without anything more serious than the loss of a bag of eggs, which made my spare tunic unwearable for days.

On the 16th we went up to another part of the line, and this time had a comparatively quiet stay; indeed, in lieu of Germans we spent our mornings having competitions at shooting the insulators off the telegraph posts. We were duly relieved after 48 hours, going for another 48 in billets before returning to the trenches. Whilst we were in billets it rained and snowed heavily, and consequently when we went up on the 19th the trench was knee deep in water. I am afraid we said some very unkind things to the regiment we relieved, but, setting to work with empty biscuit tins and baling hard soon saw the trench fairly dry, and by digging "soak pits" we managed to keep the water under.

The 21st saw our long-promised relief, and back we went for a week's rest and the chance of getting a really civilised meal and, above all, a hot bath. We got to our destination about 12 midnight, and a very tired lot we were. I slept between sheets that night for the first time in France. The next day was an orgie of hot water: the battalion was taken company by company and, you may say, sent in one door dirty in body and clothes and taken from another washed, cleanly clad, and generally renovated, in fact, almost new men. The memory of that hot bath will long remain with me as being worth a fortune—it quite altered one's outlook on life. Then tea in a really nice, clean café, or, perhaps, I should say teas, for we went the round of "Pattisseries," sampling all the most fancy of fancy cakes and imbibing chocolate and "du bon café." One great discovery we made was a place where English beer could be obtained, and although they charged 8d. a glass it was a priceless drink after the weak stuff which is sold as beer in France.

Concerts and football matches were just about to start when, on the 25th, the Germans made a big attack, and back we had to go. We went off so suddenly that we had scarcely time to get our kit together. Our company mess had, perforce, to leave behind about 50 francs worth of tinned fruits and other supplies laid in to tide us over our next spell in the firing line, not to mention two bottles of brandy, which was really unfortunate. At 11 p.m. that night we received orders to billet our companies in a village outside of which we had halted. A "patch" of village was allotted to each company, and the task of getting the men into the houses resulted in much knocking up of sleepy villagers and conversations with half-awake semi-clad French peasants taxed our somewhat scanty knowledge of French to the breaking point; however it was managed.

The fire trenches saw us again on the 27th. That night was spent in digging a stretch of new trench, and although we had the whole of two companies out in the open at about 300 yards from the German lines, only three casualties occurred. It is surprising how quickly one digs when bullets are flying about. We passed a more or less peaceful day on the 28th, but the 29th opened with a heavy greeting of "minenwefers" just as we were thinking about breakfast. Luckily no damage was done, but directly the mortars stopped we were attacked by the infantry in some force. We gave them such a warm reception, however, that few, if any, of the attacking force got back to their own lines, while we took a few prisoners.

The troops that made the attack were, apparently, fresh, as they had nice clean uniforms and nice new rifles, and if that was the case they certainly did not have a very encouraging start. The remainder of the day was more or less quiet, and on the 30th the hard-worked division was finally relieved, and went back for a long rest, to be thoroughly refitted for its next spell "dans les trenchés."

Vignettes from France.

V.

Their regiment had only come up the previous evening as supports, but here were four of them, all lightly wounded and talking as quickly as they could in their own language. Since they belonged to a "mixed" native regiment it was just possible we might have some food that they would eat, but in the absence of their "gram" we discovered it was only possible to give them milk, of which they drank freely from the metal bowls each extracted from a haversack.

They were all very quiet and good while their wounds were being dressed, but as soon as that was finished they again commenced to talk rapidly, quite good humouredly, but there was obviously something at stake, and two of them especially seemed to become more heated as the discussion progressed. Evidently there was some knotty point to be decided, and at the end of about half-an-hour one of them seemed to be out of it and composed himself to sleep. The other three were still talking and seemed no further forward than they had been when the ambulance broughf them in.

At this stage of the proceedings an Indian Supply and Transport Officer walked into the little house we were using as a dressing station and asked to be allowed to see the Indian wounded whom he had heard were there. We were only too glad that he should do so, and asked him to try and find out what it was they were all so worried about. He promised to do his best for us, and went into the room they were lying down in. They greeted him as one man, even the sleeper seemed to know that an officer who understood his language was in the room and roused himself to take part in the discussion afresh.

After a short interrogation the officer could be seen to smile. The mystery was about to be solved, and we crowded round to discover what it was which had caused so much energy to be expended. "They were disputing," said the officer, "which of them had the honour to be the first man wounded in the regiment."

Guy's Hospital Physiological Society.

At a Meeting of the above Society held on Monday, March 1st, Mr. Steavenson read a paper on "Life in Mars." The attendance was rather poor, most members feeling that the subject of the paper had no direct bearing on physiology as far as it concerned them. In a well prepared paper Mr. Steavenson pointed out the Astronomical reasons which lead to the conclusion that life had existed or still existed on Mars. He described the telescopic appearance of this planet at different times of the year, showing that these indicated seasonable variations of the same nature as those on earth. He pointed out that the appearance of the canals could not be explained satisfactorily by probability, and that the regular manner in which these canals consistently meet at oases spoke for the artificial nature of these canals.

The discussion which took place after the paper was centred more on the physics and astronomy of the subject than on the physiology. From this physiological point of view the most important matter discussed was the diurnal variation of temperature on Mars. Mr. Maxwell pointed out that the difference between the day and night temperature on Mars would be very great on account of her atmosphere. Although figures were given, it was a pity that Mr. Maxwell did not give calculations to show that this daily variation in temperature was not greater than that which we know to be compatible with earthly protoplasm. On the whole most of the members present treated the possibility of life on Mars as a serious matter, and when conditions on that planet were not favourable, did not hesitate to postulate new forms of protoplasm, and new mechanism of defence; One member having quoted at one time the probability of spore formation in this connection, rather contradicted his former view of the Martian belonging to a higher form of evolution.

The discussion was carried on till about 6.30 p.m., when the meeting closed with a hearty vote of thanks to Mr. Ryffel for having taken the chair, and to Mr. Steavenson for his excellent paper.

Papers by Guy's Men.

F. W. Cock, M.D., F.S.A.: Ether as a disinfectant. *Brit. Med. Journ.*, February 27th, 1915.

Sir James F. Goodhart, LL.D., M.D., F.R.C.P.: The injection treatment of hæmorrhoids.—*Practitioner*, March, 1915.

E. P. Poulton, M.D., M.R.C.P.: Can exophthalmic goitre be spread by contact?—*Lancet*, February 27th, 1915.

Frederick Taylor, M.D., F.R.C.P.: A case of multiple pulsating tumours secondary to hypernephroma.—*Lancet*. March 6th, 1915.

F. D. Saner, M.B., B.C.: Congenital syphilis.—*Proc. Roy. Soc. Med., Sect. for the Study of Dis. of Childn.*, February, 1915.

—— and H. W. Barber, M.D., B.C.: Enlarged liver in a boy aged 15 years.—*Ibid.*

H. W. Barber, M.D., B.C.: Pityriasis rubra pilaris associated with pregnancy.—*Ibid., Dermatological Sect.*, February, 1915.

A. C. Jordan, M.D.: Discussion on new methods for localisation of foreign bodies.—*Ibid., Elect. Ther. Sect.*, February, 1915.

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Lieut.-Col. G. T. Birdwood, M.D., I.M.S.: Observations at some hospitals at home.—*Indian Med. Gazette* February, 1915.

Nursing News from those on Active Service.

Matron's Office,
March, 1915.

All correspondents write they are busy, but the details of their work do not vary, with the exception of more medical cases owing to the weather. The same is reported from Queen Mary's Hospital, Southend, and the Red Cross Huts at Netley.

Nurse E. M. Fletcher has recently joined a private unit at The Casino Hospital, Fécamp,

"A good crossing—met at Havre by the ambulance and drove through snowstorms about 25 miles—had to pass through several barricades. This Casino makes a splendid Hospital considering the difficulty of turning such a building to medical use. The staff all stay at an hotel about two minutes walk away. We are allowed a bath a week, and you will see this is a great luxury when I tell you until our party arrived and had a bath fixed in the hotel at their own expense, there were only two baths in the whole of Fécamp.

A convoy of 104 wounded arrived yesterday, 25 cases came to us. They are all French or Algerians. Many cases of pneumonia, and all frightfully dirty and wet from the trenches. All declare they do not want to go back. One poor man had his leg put in plaster straight away, four days before arriving, and it was in a fearful condition. There is a French Red Cross Hospital here."

Sister Jentie Paterson writes:—

"We are putting up a canvas town here, the cliffs will soon be covered. Two more Hospitals besides our own. From the windows we see quite a lot of naval activity. Sir Berkeley Moynihan was round the other day as a consultant.

The frost-bites are now treated by exposure to the air, no socks or bed-clothes, massage when possible. Very busy, but nothing special of interest to report."

Miss Ames (Guy's Institution), of No. 8 Clearing Hospital, acknowledging the receipt of some bandages for the femur cases, made in many-tail style, says: "The bandages are most useful and we should like more! they pin over so easily and the limb can be kept still."

From Lahore comes news of wounded. Miss Kate Webb, the Lady Superintendent of the Mayo Hospital, sends information as follows;—

"The Mayo Hospital in Lahore has been busy receiving its first two batches of wounded Sepoys from the Persian Gulf and from East Africa. Fifty-seven men in all have been admitted, and wonderful are their tales and their descriptions of their experiences. Not many were badly wounded, and most of them were able to sit in the sun on the verandahs most of the day. Gifts of clothes, fruit, and cigarettes were showered upon them at Christmas time until one feared for their digestions! The Maharajah of Kashmir sent his Prime Minister to present money to each man, which pleased them immensely. Some of the men are leaving for their homes as they are pronounced quite fit, and soon their places will be filled by yet another contingent. The wards have been specially fitted up for their comfort, and look most cheerful and smart."

Miss Cosby, writing from No. 12, to Matron:—

"Thank you for the Guy's post-card. I was very glad to get it. I am still here with Miss Hiles—both on night duty in the medical section.

We have from eight to ten tents each, with twelve beds in each—many bad pneumonias, rheumatisms and ? enteric; also we have numbers of the local sick from the bases near. We shall never grumble at the English weather after this—all varieties. I've known a hard frost and a thunder storm in one night. It is very cold on night duty, and we long for the lovely ward fires of Guy's. Electric light is now laid on to the tents, however, and it is a great improvement upon the old smoky lamps. We have a large enteric tent, and cases come from all over. I believe I am right in saying that there has not been a single death of an inoculated patient. Miss Moriarty met Sisters Beardshaw and Wilson, off to join No. 12 ambulance train. The Gazette is passed all round when it arrives, and then goes on to No. 6 general."

Miss F. L. Brown, writing from the Anglo-American Hospital, Wimereux:—

"Here there are quite a number of Guy's people, nurses and men, in the hospitals around. Major Davies-Colley is at a hospital just across the road. This is a sweet little place, and the country round is very pretty. We motored to Calais one day and saw the wire entanglements and trenches. Another day we went over the *Guildford Castle*, the Indian hospital ship. It is beautifully fitted and well arranged. They can take 360 patients. No women at all on board."

Sister Kiddle, at No. 8 Clearing Station:—

"Thanks so much for the useful parcel. I wish you could see how the things are appreciated. People at home are good in sending, and in consequence our Tommies can travel in comfort with socks and mufflers. We have been extra busy lately. We are hoping for leave, and yet it makes one feel dreadfully selfish to take it with such heaps to do here."

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the Gazette *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Bibliography

of the Published Writings of the late THOMAS BRYANT, F.R.C.S., Hon. M.Ch. R.U.I., Hon. M.D. Dublin, Hon.F.R.C.S.I.

COMPILED BY J. H. E. WINSTON, Wills Librarian.

(Continued)

1881.

Case of suppuration of the knee-joint, associated with phthisis, amputation, recovery, with disappearance of chest symptoms, *South. Pract., Nashville,* 1881, iii., 371-374; and *Lancet*, 1881, ii., 742.

Osteo-sarcoma of femur, amputation at hip-joint, Davy's lever, recovery, subsequent return of disease in stump and deposit in lungs, death, *Lancet*, 1881, ii., 791.

Caseous osteitis of upper end of tibia, recovery, *Lancet*, 1881, ii., 909.

Innominate aneurysm, ligature of left carotid, arteritis deformans of aorta, œdema and gangrene of the left lung, death, *ibid.*, 546.

Reducible inguinal hernia, Dr. J. H. Warner's operation for radical cure, with remarks, *ibid.*, 374.

Contused femoral artery, occlusion of vessel, recovery, *ibid.*, 88.

On gastrostomy, with two successful cases, one for cicatricial, and the other for cancerous stricture, *ibid.*, i., 572-574.

Vesical calculus, lateral lithotomy, abscess opening through umbilicus, recovery, remarks, *ibid.*, 330.

Colloid cancer of rectum, successful colotomy, subsequent perforation and suppuration of cæcum, peritonitis, death, *ibid.*, 1026.

Old standing stricture of the urethra, cystitis, foreign body in bladder, external urethrotomy, suppurative peritonitis, perforation of bladder, bed-sore, death, *ibid.*, 456.

Compound fracture of lower end of femur, acute gangrene, fatty embolism, death, *ibid.*, 618.

1882.

Case of excision of a stricture of the descending colon through an incision made for a left lumbar colotomy, with remarks, *Brit. Med. Jour.*, 1882, i., 461; and *Proc. Roy. Med. and Chir. Soc.*, 1882, ix., No. 4, 149.

A successful case of gastrostomy for cancer of the œsophagus, with remarks on the value of a small opening into the stomach, *Lancet*, 1882, i., 726-728.

Large collection of pus simulating ovarian tumour, pelvic cellulitis, vaginal incisions and drainage, *ibid.*, 1032.

Ruptured liver, death, *ibid.*, 1032.

Disease of knee, necrosis of nearly the whole of the shaft of the femur, excision, with removal of sequestrum, *ibid.*, 141.

Two cases of cancer of rectum, *Lancet*, 1882, ii., 528.

Contused abdomen, hæmorrhage into iliac fossa, cure, *ibid.*, 102.

Ruptured small intestine, followed by slight collapse, death in 24 hours, *ibid.*, 102.

Hydatid of liver, paracentesis twice, relieved, *ibid.*, 101.

Epithelioma occurring in an ulcer and in an old cicatrix, *ibid.*, 350.

Aneurysm of both popliteal arteries, one cured by pressure, the other by means of Dr. Fleet Spier's artery-constrictor, after the failure of Esmarch's bandage, the operation being conducted under strict antiseptic precautions, *Brit. Med. Jour.*, 1882, ii., 721.

Case of oil cyst removed from the parotid region, *Trans. Path. Soc.*, 1882, xxxiii., 302.

A successful case of lumbar colectomy, or excision of a stricture of the descending colon, through an incision made for a left lumbar colotomy, with remarks, *Med. Chir. Trans.*, 1882, lxv., 131-146.

1883.

Compound subastragaloid dislocation inwards of foot, fracture of head of astragalus, removal of head of bone and reduction, recovery with some movement of limb, *Lancet*, 1883, i., 948.

Fracture of lower end of humerus, occlusion of brachial artery, relieved, *ibid.*, 948.

Fracture of tibia and fibula, division of tendo-Achillis to correct displacement, recovery with good limbs, *ibid.*, 948.

Recto-vaginal fistula, colotomy, death *ibid.*, 725.

Stricture of rectum, obstruction, colotomy, well, *ibid.*, 725.

Cases of acute necrosis, *ibid.*, 12.

Sarcoma of temporal bone, compressing cerebellum, and causing facial paralysis, death, *ibid.*, 142.

Hæmatocele of tunica vaginalis following tapping of hydrocele, incision, recovery, *ibid.*, 451.

Old hip disease, head carious, no necrosis, no sinus, perforation (?) of acetabulum, recovery with useful limb, *Lancet*, 1883, ii., 634.

Case of disease of the upper jaw, *ibid.*, 100.

Distension of frontal sinus, incision, drainage, cure, *ibid.*, 279.

A case of charbon, or malignant pustule, *Trans. Path. Soc.*, 1883, xxxiv., 293.

In memoriam, Joseph Towne, Modeller to Guy's Hospital for fifty-three years, *Guy's Hosp. Rep.*, 1883, 3rd ser., xxvi., 1-12.

The surgical affections of the tongue, *ibid.*, 101-146.

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Separation of the lower epiphysis of the femur, with displacement inwards, reduction of the parts, and recovery with a good limb, *Brit. Med. Jour.*, 1884, i., 1044.

Carcinoma of the buttock, growing from a sebaceous cyst of twenty years' duration, cured by excision, *ibid.*, 1044.

Acute gluteal abscess following injury, treated by free incisions and irrigation with iodine water, *ibid.*, 1044

Lacerated wound of the throat into the larynx and pharynx by broken crockery, recovery, *ibid.*, 164.

Rapid and extensive emphysema with severe collapse, from passage of a cart-wheel over the thorax, treated at once with marked relief by multiple punctures of the skin, rapid convalescence, *ibid.*, 163.

Fracture of the base of the skull, hæmorrhage and discharge of cerebro-spinal fluid from the ear, ecchymosis of the outer canthus, recovery, *ibid.*, 163.

Angular deformity after excision of the knee, osteotomy of the femur, *Brit. Med. Jour.*, 1884, i., 1045.

Spina bifida, injection of Morton's solution of iodine into the sac, early rachitic condition of the skull, death on the fifth day, *Brit. Med. Jour.*, 1884, i., 163.

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Harveian lectures on the mode of death from acute intestinal strangulation and chronic intestinal obstruction, *ibid.*, ii,, 1001, 1057, 1111, 1182, 1228.

Two cases of fracture and dislocation of the cervical spine, *Lancet*, 1884, ii., 14.

Two cases of lupus, scraping, and application of carbolic acid, *ibid.*, 234.

Case of fracture of the base of the skull, *ibid.*, 318.

Scalp wound followed by brain symptoms, trephining on the thirteenth day, temporary relief, death on the twenty-fourth day after the accident, suppuration of cerebral meninges, broncho-pneumonia, *Lancet*, 1884, ii., 823.

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Lipoma of palm of hand simulating ganglion, excision, wound dressed with terebene and oil, and washed with iodine water, recovery without suppuration, *ibid.*, 846.

Injury to head and spine, cystitis, suppurating kidney, softening of cord, death in one month, *ibid.*, 1120.

Cases of epithelioma originating in chronic ulcers or in a cicatrix, *ibid.*, 341.

Malignant stricture of rectum, colotomy, improvement, *ibid.*, 203.

A case of suppuration of the knee-joint, associated with phthisis, *Med. Soc. Trans.*, 1884, vi., 7-12.

Gastrostomy for cancer of the œsophagus, *ibid.*, 184.

On inflammation, suppuration, and ulceration of the tongue, *ibid.*, 258-276.

The guiding principles of operative surgery, *Med. News, Phila.*, 1884, xlv., 477-479.

1885.

Multiple melanotic sarcomatous nodules of the skin of the foot, amputation of the leg by Teale's method, *Lancet*, 1885, ii., 289.

Compound depressed fracture of frontal bone, cure by natural processes, *ibid.*, 289.

Large unilocular ovarian cyst, strangulation of the cyst from twisting of the pedicle, ovariotomy, rapid recovery, *ibid.*, 289.

Inguinal aneurysm (traumatic), ligature of external iliac artery, cure, *ibid.*, 64.

Occlusion of right femoral artery from severe contusion, recovery, *ibid.*, 65.

Occlusion of right popliteal artery from severe contusion, fracture of fibula, lacerated wound of left knee followed by suppuration of the joint, free incisions into joint, recovery, *ibid.*, 65.

Lipoma of the scalp, excision, cure, *Lancet*, 1885, i., 983.

Intra-parietal strangulated inguinal hernia, operation, recovery, *ibid.*, 983.

Dislocation of the left knee-joint outwards, reduction, cure, *ibid.*, 983.

Inaugural address on the necessity for precision and the advantage of co-operation, *Brit. Med. Jour.*, 1885, i., 371.

The operation of laparotomy, hair-pin (3½ in.) introduced into rectum, and removed from the sigmoid flexure of colon, *Med. Press and Circ.*, 1885, n.s., xxxix., 228-230.

On amputation at the knee-joint by disarticulation, with remarks on amputation of leg by lateral flaps, *Lancet*, 1885, ii., 1095, and *Proc. of Roy. Med. Chir. Soc.*, 1885-6, n.s., ii., 26-33.

On treatment of irreducible hernia, and an improved method of adapting a truss in all forms of hernia, *Med. Soc. Trans.*, 1885, vii., 181-186.

Discussion on the treatment of fracture of the patella, *ibid.*, 24.

Presidential address delivered at the Clinical Society of London on February 13th, 1885, *Clin. Soc. Trans.*, 1885, xviii., liii.-lix.

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Bullet wound of forehead, division of left optic nerve, occasional epileptiform seizures, coma, death, necropsy, *Lancet*, 1886, i., 971.

Address on the value of exploratory operations in the practice of surgery, *Lancet*, 1886, ii., 909-913.

On lumbar colotomy as a curative and remedial operation in syphilitic, simple, and cancerous ulceration of the rectum and colon, with an improved method of performing the operation, *Cong. période internat. d. sc. méd. Compt. rend.*, 1884, Copenh., 1886, ii.. Sect. de Chir., 5-36.

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Cystic tumours of the breast, *Guy's Hosp. Rep.*. 1886, 3rd ser., xxviii., 435-486.

1887.

Popliteal aneurysm treated by digital compression for twenty-two hours, cure after previous failure of Esmarch's bandage and electrolysis before admission, *Lancet*, 1887, i., 1230.

Round-celled sarcoma after prolonged suppuration of antrum, partial excision of superior maxilla, *ibid.*, 1231.

Recto-vesical fistula, due to malignant disease, colotomy (two stages), pins used, *ibid.*, 1887, ii., 822.

Necrosis of the lower jaw, death, necropsy, *ibid.*, 774.

Sarcoma of the femur, spreading from an aperture in the bone to the periosteum and knee-joint, amputation of thigh, recurrence, *ibid.*, 773.

Syphilitic necrosis of tibia, fracture at this spot, sequestrotomy, *ibid.*, 823.

Seven consecutive cases of charbon successfully treated by excision, *Lancet*, 1887, i., 367, 416.

Fractured patella, a clinical lecture, *Guy's Hosp. Gaz.*, 1887, i., 29.

Strangulated hernia, a clinical lecture, *ibid.*, 217.

1888.

Irreducible suppurating bubonocele, exploration removal of suppurating omentum, recovery, *Lancet*, 1888, ii., 814.

Progressive caries of the tarsus, multiple exostoses, *ibid.*, 765.

Compound depressed fracture of the skull, with paralysis of eye, trephining, recovery, foreign body in the external ear, leading to suppurative otitis media and pyæmia, death, necropsy, *ibid.*, 912.

Extensive burn of left arm and thigh, alveolar abscess, necrosis, removal of the left condyle of the lower jaw, complete movement, *ibid.*, 815.

Lecture on cranial and intracranial injuries, *ibid.*, 405, 507.

Amputation at the knee for epithelioma of the left leg, and for recurrent melanotic sarcoma of the right leg, *ibid.*, 715.

Lectures on the causes, effects, and treatment of tension as met with in surgical practice, *Lancet*, 1888, i., 1231, 1279; also *Med. Press and Circ.*, 1888, n.s., xlvi., 2, 29.

Case of otorrhœa, otitis media right side, trephining middle ear, result, convalescent, *Med. Press and Circ.*, 1888, n.s., xlv., 28.

Right femoral aneurysm in Scarpa's triangle, ligature of external iliac, sloughing over outer side of right leg, necrosis of right fibula, sequestrotomy, result, cured, *ibid.*, 57.

A case of chronic intestinal obstruction, right lumbar colotomy followed by right inguinal enterotomy (Nélaton's operation), relief, volvulus of the cæcum. *Clin. Soc. Trans.*, 1888, xxi., 142-145.

(To be continued.)

Rugby Football.

R.A.M.C. OFFICERS, ALDERSHOT, v. R.A.M.C. OFFICERS, EASTBOURNE.

Though this was the only match played on our ground this year, its quality made up in some respect for the absence of others. How different the scene to normal times: instead of numerous students and crowds of spectators, just a few of the former and not many of the latter turned up. Many onlookers were in khaki. Some of our own men not actually playing were in service uniform and had come to watch their comrades. What of the sides? Before we discuss them from a football point of view, one must remark on the fine sight these gallant thirty made, gathered with other officers under the glass of the club house. A splendid lot of men, a credit, indeed, to their profession, to their hospitals, and to themselves. Never has our club house beheld a scene like it, and the writer was indeed privileged to witness what will prove to be an occasion in the History of Guy's Football Ground which men will look back on for years to come. L. G. Brown, Quin (of Ireland), J. B. Minch (his colleague of the three-quarter line), C. S .L. Roberts, T. B. Batchelor and A. C. Palmer (both of England and London Hospital), L. R. Broster, Greville and Treherne (of Thomas's), Dowse (the Irish International), and Williams (of Bart.'s), and a host of other well-known Rugger men made the teams.

A glance at the list of players will show that Aldershot were the better-known players, and they ran out easy winners by 30 points to 4. In the first half Palmer, Quin, and Broster scored tries. From Broster's try Quin made an excellent shot at goal, but an opponent touched the ball in flight and, of course, no goal was allowed.

Ends were changed, and in rapid succession Palmer got over on two occasions, both good efforts; the second try specially calls for notice as Palmer was hampered by proximity to the touch line, but he got clear and scored by the posts. Both tries he goaled. Dowse then got a try and Palmer followed with another near the flag. Starkie did his utmost to prevent it, but the old International was too much under way to be stopped. Hartgill next dropped a clever goal for Eastbourne, but this was their only success. They were rather out-classed by the massed talent from Aldershot. The game closed with a try by the Irish International player, Minch, who dribbled over in a good position for Palmer to convert. Final score: Aldershot R.A.M.C., 3 goals 5 tries, 30 points; Eastbourne R.A.M.C., 1 dropped goal, 4 points. Teams:

ALDERSHOT.—J. C. McConkey (Lansdowne); J. C. Quin (Ireland), J. B. Minch (Ireland), A. C. Palmer (England and London), and R. D. Grandy (Lansdowne); L. R. Broster (Oxford and Guy's), and R. H. Williams (Bart.'s); L. G. Brown (England, Oxford, London), J. C. Dowse (Ireland), C. S. L. Roberts (Guy's), R. A. MacGrath (Bective), H. P. Whitworth (Guy's), E. G. Greville (St. Thomas's), R. A. B. Cole (Durham), and F. G. Flood (Trinity).

EASTBOURNE.—R. P. Starkie (St. Thomas's); T. B. Batchelor (London, England), H. G. Hartgill (London); S. M. Jones (University), and —. Fitzgerald (Lansdowne); O. de Burgh-Marsh (London), and H. G. Morriss (London); H. S. Milne (Aberdeen), C. W. Treherne (St. Thomas's), O. G. Parry-Jones (Guy's), G. V. Bakewell (London), J. C. Kidnet (Middlesex), V. Glendining (Guy's), E. R. Lovell (Middlesex), and C. W. Meyer (Edinburgh).

Referee: Mr. J. G. Saner (Guy's Hospital).

Births.

VISICK.—At Tintagel, Cecil Park, Pinner, on February 24th, the wife of Hedley C. Visick, L.D.S. (also of 29, Queen Anne Street, W.) a son (Anthony).

CAMERON.—On the 17th February, at 6, St. Thomas's Street, the wife of Dr. H. C. Cameron, of a daughter.

W. E. T.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE Ophthalmic Formulæ which are to be inserted into the new edition of the Guy's Pharmacopœia are published in this GAZETTE. We should like to point out that these formulæ are only provisional, and one object in publishing them is to invite criticisms and suggestions. The response of Guy's men to our previous appeal for help in compiling the new Pharmacopœia has been very unsatisfactory, so it is hoped that publication in the GAZETTE will be more successful in attracting suggestions and additional formulæ. With this aim in view, further lists for the other special departments will appear in the GAZETTE.

A special Pharmacopœia is being prepared for Dental Surgeons, and will be published separately. This book will contain the special materia medica required by dentists. The Hospital Pharmacopœia will have only dental formulæ which are frequently used by medical practitioners.

In August a committee of members of the medical profession was appointed to consider the ways in which economies might be effected in the use of those drugs which, owing to the war, had become limited in supply. A confidential circular was issued to the medical profession containing a list of drugs of which supplies were short, and suggestions were made as to the measures which the medical profession might usefully adopt in co-operating to conserve such supplies of these drugs as were available.

This month a revised circular has been issued containing drugs of which stocks are now low and difficult to replenish. These drugs should not be witheld in cases in which they are really needed, but the use of them should be restricted as far as possible to those therapeutic purposes for which no satisfactory equivalents are known. Owing to the great demand for carbolic acid for war purposes, it should be used as sparingly as possible, for example Liq. Cresol Sap. B.P. is a convenient substitute,

The salicylate group of drugs should be reserved for the treatment ef acute rheumatism and its complications. In conditions loosely termed "rheumatic," other drugs should be employed.

Salol, novocaine, eucaine, hydrochloride, eucaine lactate, should be used with the strictest regard for economy.

Economy in the use of atropine is now essential. Substitutes can hardly be suggested, but the Committee state that there is reason to believe that it is sometimes used in cases in which it is not definitely called for. Preparations containing thymol should be sparingly prescribed, especially as mouth washes, gargles, etc. Adeps lanæ, adeps lanæ hydrosus (lanoline) should be economically used. The following ointments in the B.P., 1914, contain wool fat:—Unguentum hamamelidis, ung. lanæ compositum, ung. plumbi subacetatis. It is advised that paraldehyde be reserved for cases (mainly occurring in asylum practice) in respect of which its deprivation would be seriously felt.

Phenazone and phenacetin should not be used as antipyretics.

On the other hand, potash salts, bromides, formaldehyde and hexamine (hexamethylenetetramine) may now be more freely employed.

The Local Government Board issued a Circular on Maternity and Child Welfare to County Councils and Sanitary Authorities in July last year, which pointed out that an estimate had been laid before Parliament for a grant to be distributed by the Board in aid of the expenditure of local authorities and voluntary agencies in respect of institutions or other provision for maternity and child welfare.

It had become evident from the reports issued by the Medical Department of the Board, and that of many Medical Officers of Health, that more extended and systematic measures were necessary. Local authorities in their infant welfare work had concerned themselves more especially with the child in its first year of life, but it is clearly desirable that there should be continuity in dealing with the whole period from before birth until the time when the child is entered upon a School Register, *i.e.*, the Register of a Public Elementary School, Nursery School, Crêche, Day Nursery, School for Mothers, or other School.

In order to encourage local authorities to undertake this more extended work, grants were promised to such districts whose schemes have been approved by the Board. The grants thus obtained would cover initial expenses and include half the salaries of health visitors and other officers engaged for this work.

The following Memorandum, which has been prepared by the Board's Medical Officer with a view to assisting the formulation of schemes, or extending the work already undertaken, sets forth in outline the matters needing consideration in the preparation of a comprehensive scheme:—

A complete scheme would comprise the following elements, each of which will, in this connection, be organised in its direct bearing on infantile health.

1. Arrangements for the local supervision of Midwives.

2. *Ante-Natal:*—

   1. An Ante-natal Clinic for expectant mothers.

   2. The home visiting of expectant mothers.

   3. A Maternity Hospital or beds at a hospital, in which complicated cases of pregnancy can receive treatment.

3. *Natal:*—

   1. Such assistance as may be needed to ensure the mother having skilled and prompt attendance during confinement at home.

   2. The confinement of sick women, including women having contracted pelvis, or suffering from any other condition involving danger to the mother or infant, at a hospital.

4. *Post-Natal:*—

   1. The treatment in a hospital of complications arising after parturition, whether in the mother or in the infant.

   2. The provision of systematic advice and treatment for infants at a Baby Clinic or Infant Dispensary.

   3. The continuance of these Clinics and Dispensaries, so as to be available for children up to the age when they are entered on a school register, *i.e.*, the register of a Public Elementary School, Nursery School, Crêche, Day Nursery, School for Mothers, or other school.

   4. The systematic home visitation of infants and of children not on a school register as above defined.

Although the Circular of the Local Government Board was prepared and issued before the Declaration of War, it will be seen that at this particular juncture any scheme concerning the welfare of children must be considered as of very special importance to the Nation, and it is encouraging to know that the response to the appeal of the Local Government Board has been very good,

It is hoped that soon we shall have completed the organisation which shall ensure for this country its first line of defence, viz., *the physical fitness of its people.* For we shall have, first the expectant mother, then the child and mother, well looked after; afterwards the child at school; then from 16 years onwards he will come under the National Health Insurance Act. Thus we shall be, perhaps, in a somewhat niggardly way at first, but nevertheless surely, looking after what must always be in the final estimate of things a Nation's Chief Asset, the Health of its People.

Seventy-seven sisters and nurses have left the Hospital and Private Nursing Staff to nurse the soldiers abroad and at home, There are between 150 and 200 past Guy's nurses at work in France or in home hospitals. The Matron also expects to send out a great many nurses during the next few months.

In response to our appeal for further names of Guy's men serving, we had a letter from an old Guyite who was a House Surgeon in 1878, and is now on duty as a lieutenant in the R.A.M.C. at the Pitt Military Hospital, Chatham.

We congratulate Surgeon K. H. Hole, R.N. (Guy's, 1902-1908) on being one of the fortunate few who were saved from the *Bayano*, recently torpedoed while on patrol duty.

A meeting of the Committee of Landon Out-Patient Tea Fund was held this week. The statement of receipts and expenditure is published in this issue, and shows a balance in hand of £29. Of this surplus £25 is to be paid to the Work's Department towards the expense incurred in making the tables and forms. The catering done by the Hospital and arranged by Sister Out-Patients proved very satisfactory, and it is hoped to continue this arrangement in the future.

LANDON OUT-PATIENT TEA FUND.

Christmas, 1914.

Statement of Receipts and Expenditure.

Receipts.

To Balance brought forward from last Account	£31	10	4
„ Donations, Collections, &c.	66	4	10
	£97	15	2

Expenditure.

By Cost of Tea (Hospital Caterer's Account	£11	7	5			
„ Groceries, Provisions, Fruit, &c.	18	10	7½			
„ Clothing	10	1	6			
„ Toys	18	4	8			
„ Decorations, Flowers, &c.	2	3	0			
„ Printing, Stationery & Postage	3	0	3½			
„ Police Fees, Gratuities, &c.	5	0	6			
				68	8	0
„ Balance carried forward:— Cash at Bankers				29	7	2
				£97	15	2

Audited and found correct.

March 19th, 1915. CHAS. H. WELLS.

Little girl (greatly impressed on seeing a number of Red Cross workers): "Why, mother, they're dressed like Auntie Mary (referring to one of our nurses), only she hasn't got a windmill on her chest."

SYMPTOMS.

When your head is bumping, bumping,
When you feel an awful thumping
Around the middle regions of your back,
When your eyes are madly aching,
When you think your legs are breaking,
And everything is looking very black.

When you sit and shiver, shiver,
And you wonder if you liver
Has shifted from its usual residence.
When your joints are weirdly creaky,
And your voice is very squeaky,
And you feel as though you're really "passing hence."

When you sadly think of quitting
This ungrateful world, and flitting
To a haven far beyond the boundless "blue."
When your bed is like a girder,
And you want to bellow "Murder!"
You may rest assured you've really got the "flue"!

With acknowledgements to the *Standard*.

Pass List.

Royal College of Surgeons.

FINAL EXAMINATION FOR THE LICENCE IN DENTAL SURGERY.

March, 1915.

Parts I. and II.—C. A. E. Cook.

Part I.

L. H. Cross.	F. H. Wallace.
P. L. van Schalkwijk.	G. W. Wheldon.
W. J. Rousseau Viljoen.	C. L. Curle.

Part II.

*H. Canton.	*P. T. Pearce.
*P. E. Bernhard.	*F. E. Rudd.
*T. D. Corke.	*P. King.
*J. L. Garrard.	*H. V. Stebbings.
*J. J. S. Hill.	

* Denotes completion of examination.

Gazette Special Pathologist.

T.L.J., Cheadle.—This sputum contains a little muco-pus, but tubercle bacilli are not detected.

PATHOLOGIST.

Nursing News from those on Active Service.

On Saturday, March 27th, Nurses Jessie Foxon, Violet Tyler-Cove, and M. Tyndall leave Victoria as members of the C. H. R.

Miss E. Randles, who has been out with the Red Cross, has been invalided home. Also Miss Beloe (Matron of Sudbury Hospital), Q.A.I.M.N.S.R.

From Queen Mary's Convalescent Home for British Officers, Cimiez, Nice (according to the photographs a splendid building, well situated), Miss F. Hall writes: "Have been here since January, but we close at the end of April. We have had a great number of officers here, both medical and surgical cases, and in this beautiful place the change in them has been wonderful before they return to the front."

A hasty note from No. 11, General Hospital, 14th March:—"Pardon brevity, but thought you would like to know we are simply ramping; theatre going all night and **day.**"

Nurse Ames reports the same influx of patients at the Clearing Hospitals. She acknowledges the receipt of two or three dozen bandages with thanks, but, as the letter reports the number of the last convoy as 400, 36 bandages do not appear worthy of notice!

From No. — Ambulance Train:—"Thank you so much for the parcel of woollen goods that arrived so unexpectedly. A good many of them went to the Toothless Brigade, who are doing pioneer work at our siding at Boulogne. These are men who have such bad teeth that they cannot manage to eat bully beaf and biscuits as supplied at the trenches, and there are too many of them to deal with and send back, so they have to work at bases where there is other food.

"'Pioneer work' is any dirty work of clearing up. The men at Versailles used to say, when we rushed round in the morning washing ash trays and locker tops, 'Hallo, Sister, on pioneer work?' It *always* is wet at Boulogne, so these poor men have a wretched time. It is very interesting visiting the different places in between journey, and we often have time to visit other hospitals. One was an enteric hospital established by the British Government in a Jesuit College to deal with a serious outbreak among Belgian refugees. There were 370 cases, mostly women and children.

"On the train, of course, there is not much nursing work. We make the patients comfortable and do what dressings are necessary. Our shortest journeys are six hours and the longest about twenty-four. In that time we get the patients washed, the top layers off, anyhow; oh, they do appreciate it—the relief of the soap and hot water, and a good meal, too, for the food is excellent, including a splendid stew and vegetables. It is remarkable the difference one can see in the patients by the end of the journey. The delight of being in a place that is 'clean,' away from the mud and rain and safe from the horrors of the awful trenches rests their nerves in a surprising way."

From Cairo, the Kars-el-Aim Hospital, comes news of war. Miss Mary Bollard says:—"This place is used as a hospital for Turkish prisoners of war. There were 160 of them, chiefly head cases; many of them died. There were also a large number of fractured legs and arms, and I was struck with the fact there was not a single case of tetanus. They are all very nice men, and at first they had no desire for anything but a good sleep. Many were without boots and in very torn uniforms. In hospital they have been allowed six cigarettes each per day, fruit, and Turkish delight. They have been very good patients. Cairo is full of soldiers' camps. The 'Terriers' have improved wonderfully since they have been here, ever so much smarter looking. Miss Traill and Miss Sargeant are both very well; it is so nice having them here."

The following Institution Nurses are working in Private House Hospitals:—

Nurses Ellis and May—Lady Mabel Lindsay, Burcote, Abingdon.

Nurses Canty, Ford, Pace, and Von Pein—Mrs. Hall Walker, Sussex Lodge, Regent's Park.

Nurse Sewell—The Mount, Hadley, Barnet.

Nurse Mott—Lady Evelyn Mason, Brunton Street.

Nurse Cannell—Rushton Hall, Kettering.

Nurse Skou—The Abbey Hospital, Bedford.

Nurse L. M. Simpson (for the British Red Cross)—Lord Onslow, Clandon Park.

Change of Address.

V. Drew, 1st British Field Hospital for Serbia, c/o British Vice-Consol, Salonika, Greece.

Col. Astley Roberts, T.D., 2nd Home Counties Brigade, Royal Field Artillery, Jullundur, Punjab, India.

A. J. K. Drew, M.R.C.S., L.R.C.P., Royal Albert Hospital, Devonport.

Lt.-Col. D. Elcum, M.D., 79, Claverton Street, S.W.

Surg. A. E. P. Cheesman, R.N., Salford's Parsonage, Horley, Surrey.

(The Editor will be very glad to receive a post card with notes of any change of address.)

The Bacteriological Department, Guy's Hospital.

A short resumé of the institution and development of the Bacteriological Department may well precede the description of the new Laboratories which the Governors of the Hospital, keenly alive to scientific advances, have recently built to meet the ever-increasing demands on its resources.

At a meeting of the School Staff in November, 1888, it was resolved that "It is desirable to provide instruction in Bacteriology, and that a Committee be appointed to consider the best means of carrying this resolution into effect." This Committee reported in January, 1889, and recommended that Bacteriology should be housed in the new Pathological Room (the room adjoining the Post-mortem Room, now part of the Pathological Chemist's quarters), that the cost of the requisite apparatus and fittings should not exceed £30, that the working expenses of the Department for the first year should not exceed £5, and, finally, that a Demonstrator of Bacteriology should be appointed without salary.

Dr. Washbourn was then appointed Demonstrator of Bacteriology (H. A. Hunt, the Post-mortem Room Attendant, now Museum Attendant, acting as his Laboratory Assistant), and the subject of Bacteriology was first specifically mentioned in the Green Book for 1889-90.

With the re-building of the Petersham Block (1890-92) provision was made for separate laboratories for Bacteriology, one over the Bakehouse and the other in the renovated Practical Chemistry Laboratory on the ground floor; and in 1893 the Bacteriological Department was instituted as a definite unit of Guy's Hospital and Medical School for teaching, diagnosis, and research.

Its staff comprised Dr. Washbourn as Lecturer and Demonstrator, Mr. W. C. C. Pakes as Student Demonstrator, and a laboratory boy.

During the first years of its existence, research was the chief function of the new department; teaching was limited to one short course of lectures each winter and to practical instruction to a limited number of enthusiasts. A certain small amount of diagnosis work, to the extent of eight specimens in 1893, and a total of 150 specimens during the three years 1893-4-5, also was carried out for the hospital.

In October, 1894, Mr. W. C. C. Pakes was appointed the first Assistant Demonstrator of Bacteriology "in consideration of the increasing recognition of the value of bacteriological methods in the diagnosis of disease."

At the same time practical instruction was instituted for the benefit of candidates for diplomas in Public Health, in addition to two annual courses of lectures in general Bacteriology, and from this time, until about 1901, a fairly large number of students took out courses of instruction in Public Health Laboratory work. In 1902 the tuition of post-graduate students for Public Health Diplomas was relinquished and not resumed again until 1905-6.

Specimens from the wards for examination had by 1896-7 reached the total of over 700 per annum, and this increase in the work in the Department necessitated the increase of the Laboratory staff by the addition of a second Laboratory boy and a female "cleaner."

In 1896 a course in Microscopical Pathology, including both Bacteriology and Morbid Histology, became compulsory upon candidates for Medical Degrees and Diplomas, and classes were instituted in these subjects under the joint direction of Messrs. Bellingham Smith and Pakes. In 1902 the average number of students attending the Microscopical Pathology class was between 70 and 80. With the declining entries, resulting from the introduction of the five year curriculum, these numbers fell gradually, and since 1909 the average attendance any one year has been about 53. In 1910 it was considered expedient to devote an equal time (three months) to each of the two branches of Microscopical Pathology, viz., Bacteriology and Morbid Histology, and to alternate these two subjects throughout the entire year, so that two complete courses of Microscopical Pathology are now given in each year.

In 1900 the Demonstrator of Bacteriology received the additional title of Bacteriologist to the Hospital.

Mr. Pakes having been appointed Government Analyst and Bacteriologist to the Transvaal Colony, resigned his post at Christmas, 1901, and in April, 1902, Dr. Eyre, at that time Bacteriologist and Lecturer to Charing Cross Hospital, was appointed Bacteriologist to the Hospital and Demonstrator of Bacteriology in the Medical School, Dr. Washbourn, as Head of the Department, retaining the post of Lecturer

until the fatal termination of his long illness in July, 1902, when Dr. Eyre was appointed as his successor, and also to the newly-created post of Lecturer on Dental Bacteriology.

During the period 1902-14 the numbers of specimens examined by the Department on behalf of the hospital increased rapidly to between six and seven thousand per annum (see table), and during the first eight years of that period —until, in fact, stress of hospital work and lack of space rendered it impossible—research was vigorously prosecuted.

Year.	No. of Specimens examined.	Year.	No. of Specimens examined.
1893	8 ...	1904	1,083
1894	39 ...	1905	1,931
1895	105 ...	1906	4,147
1896	473 ...	1907	6,301
1897	708 ...	1908	5,115
1898	828 ...	1909	5,830
1899	848 ...	1910	5,326
1900	783 ...	1911	6,480
1901	1,026 ...	1912	7,019
1902	1,264 ...	1913	6,681
1903	1,065 ...	1914	6,839

In consequence of the increased amount of work further additions to the staff of workers became necessary from time to time, thus, in 1904, an Assistant Bacteriologist was first appointed. In 1905 a third laboratory assistant was introduced, and, at the same time, a woman working from 6.30 a.m. to 1 p.m. each day replaced the "cleaner."

In 1907 Dr. Eyre received the additional title of Director of the Bacteriological Department.

In June, 1907, a lady typist was installed in the Department. In 1909 a second or Junior Assistant Bacteriologist was added to the staff.

Experiments were instituted in 1904 which in the following year resulted in the tentative treatment of selected cases of bacterial infection with special vaccines prepared in the Department; and in association with Mr. Sichel, the Surgeon in charge of the Actinotherapeutic Department, of lupus and other tuberculous infections with various forms of light and tuberculin (T.R.), this work being carried out either in the wards or in the old Light Department on the top floor of the Surgical Building. Other cases were treated actually in the Bacteriological Laboratories.

In February, 1908, this Vaccine Out-Patients Department was established as a Specialist Reference Department, and is now accommodated every Tuesday and Friday in the Obstetric Room at Out-Patients under the charge of the Bacteriologist, assisted by one chief and two ordinary qualified Clinical Assistants.

Since 1911 the Assistant Bacteriologist has, as a matter of administrative convenience, been regarded as having a lien upon the post of Chief Clinical Assistant in the Vaccine Department, and the Junior Assistant Bacteriologist upon one of the remaining posts.

Records have been kept of the attendances, etc., from 1908, and are summarised in the following table :—

	1908	1909	1910	1911	1912	1913	1914
In-Patients (in Wards)	164	218	269	243	189	179	158
Out-Patients (New Cases)	200 (10 mnths)	263	234	314	307	424	468
Attendances	1052	1801	2145	2342	2273	2706	2550

The post of Assistant Bacteriologist is regarded chiefly as one of educational value to the occupant, the experience thus gained enabling him to obtain a more remunerative appointment in some other hospital. That this is so is apparent from the records of past Assistant Bacteriologists, of whom the Department has had twelve in the past eight years.

Chronological List of Assistant Bacteriologists.

1902. Beaton R. (temporary) Jan.-April, 1902.

1903. Candler, J. (temporary) Aug.-Oct., 1903. Pathologist to the West London Hospital; Assistant to the Pathologist to the London C.C.; Medical Inspector to the L.G.B.

1904. Price-Jones, C., Jan., 1904 - Jan., 1906, Assistant, Cancer Research Department Middlesex Hospital.

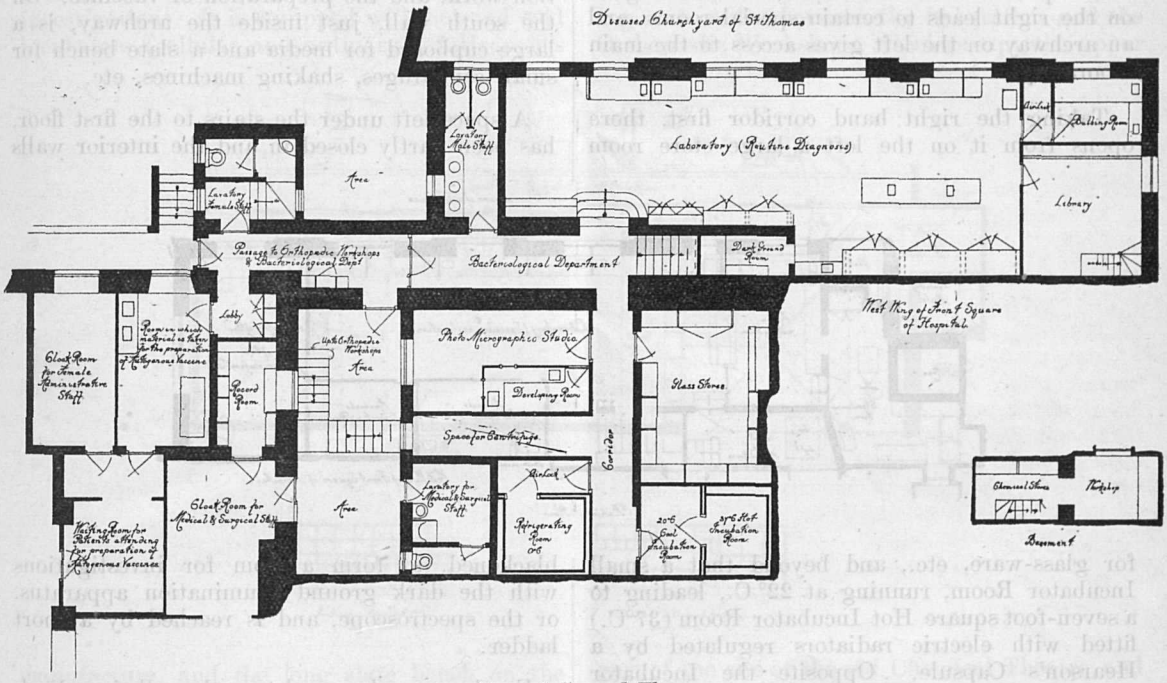
1906. Louisson, M. G., Jan., 1906 - Dec., 1906, Bacteriologist and Pathologist, Christchurch Hospital, N.Z.

1907. Wedd, B. H., Jan. - Sept., 1907. Bacteriologist to Moorfields ; Assistant, Cancer Department, Middlesex Hospital ; Bacteriologist to the Tropical Diseases Hospital, Albert Docks ; Lieut., R.A.M.C.

1908. Leeming, A. N., Jan. - Sept., 1908. Private Practice; Lieut., R.A.M.C.

1908. Minett, E. P., Oct., 1908 - Sept., 1909. Bacteriologist to Moorfields; Assistant Government Bacteriologist, British Guiana; Capt., R.A.M.C.(T.)

1909. MacAlister, G. H. K., Oct. — Dec., 1909. Assistant Bacteriologist, Lister Institute; Assist. Bacteriologist, Welcome Research Laboratory; Pathologist, Imperial Laboratory, Muktesar, India.



Plan of Ground Floor.

1909. Catto, H., (Junior) Oct. — Dec., 1909; (Senior) Jan., 1910 - March, 1911, Laboratory Director, Clinical Research Association; Assistant Government Bacteriologist, Jamaica.

1910. Browning, S. H., (Junior) Jan., 1910 - Nov., 1912. Bacteriologist to Moorfields; and Leathersellers' Technical College; Lieut., R.A.M.C.

1911. Goodhart, G. W., Nov., 1911 — March, 1913. Gordon Demonstrator of Pathology, Guy's Hospital Medical School; Capt., R.A.M.C.(T.)

1912. Passey, R .D., (Junior) Nov., 1912-Mar., 1913. Bacteriologist, Nordrach-on-Dee Sanatorium; Lieut., R.A.M.C.

1913. Lucey, H. C., March, 1913- Sept., 1914. Lieut., R.A.M.C.

1913. Keith, S., (Junior) March, 1913 — Sept., 1914. Capt., 4th Queen's West Surrey (T.).

1915. Sampson, B., (Junior) Feb., 1915, —

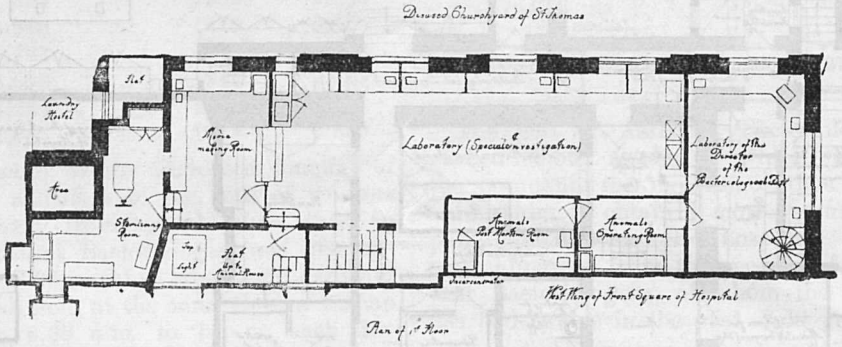
The new Laboratories, which were commenced January, 1914, occupy the site of the old Chemical Laboratory (afterwards used as a Toxicological Laboratory), the old Materia Medica Room, and the ground floor of the old Chemical Theatre, and are, therefore, situated behind the Hospital Chapel, and between it and the disused graveyard of St. Thomas's Church. The new building is on two floors, and a portion of the roof is flat to allow for the housing of animals for experimental purposes.

Entrance may be gained to the Department, as to the original Chemical Laboratories, along the narrow passage (by the bakehouse) which leads past the Laundry Hostel, or preferably by the door in the Inner Quadrangle, just past the Superintendent's Office, which formerly led to

the "Drunk or Dying" Ward. This room has now been reconstructed and adapted for the purpose of an Out-Patients' Examination Room, where blood for various serological tests may be collected or material obtained for the preparation of autogenous vaccines. In this way, patients no longer enter the Laboratories themselves, where, as has happened in the past, experimental work upon animals is in progress.

Passing through the examination room, one enters the corridor leading to the Laboratories proper, at the end of which a flight of stairs leads up to the first floor, a corridor running off on the right leads to certain special rooms, and an archway on the left gives access to the main laboratory.

Taking the right hand corridor first, there opens from it on the left a large store room



for glass-ware, etc., and beyond that a small Incubator Room, running at 22° C., leading to a seven-foot square Hot Incubator Room (37°C.) fitted with electric radiators regulated by a Hearson's Capsule. Opposite the Incubator Rooms is situated the Refrigerator Room, also seven feet square, provided with an adequate air lock. This room is not yet actually finished, as it has still to be cooled by brine pipes, connected up to the Ammonia Compressors, in the new Engine Room under Tabard House. Next this cool room is a passage in which will shortly be erected a high-power Delepine Centrifuge, to run at 8,000 r.p.m., driven by a 5 h.p. motor (the gift of Reg. H. Prance, Esq.). The room nearest the main corridor on this side is a Photomicrographic Studio, with its Dark Room for developing.

The main laboratory, in which are conducted ordinary routine diagnosis examinations, is a few feet below the level of the corridor, and is reached by a short flight of four steps. Here, immediately within the entrance, is placed the desk of the lady secretary, who receives, enters, and numbers the specimens brought for examination; and the National, inter-Hospital, and inter-Departmental telephones. A long slate bench on the north wall of the room, divided into unequal portions by glazed screens, and well lighted by windows and moveable overhead electric lights, accommodates the Assistant Bacteriologists, and provides definite places for special examinations, such as suspected diphtheritic material, complement fixation tests, section work, and the preparation of vaccines. On the south wall, just inside the archway, is a large cupboard for media and a slate bench for small centrifuges, shaking machines, etc.

A space left under the stairs to the first floor, has been partly closed in and the interior walls blackened, to form a room for investigations with the dark ground illumination apparatus, or the spectroscope, and is reached by a short ladder.

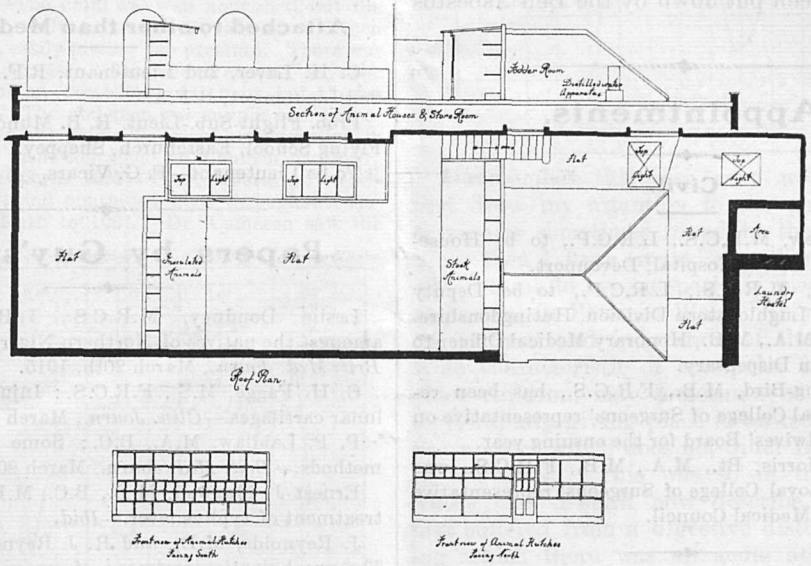
Further on, also on the south wall, is a York stone bench for a battery of small incubators and sterilisers, the space underneath being provided with doors to form cupboards. Between the incubator bench and the working bench, a third bench has been built for the use of Ward Clerks, and others, for the examination of suspected tuberculous material.

At the far end of the Laboratory are two small rooms, that on the left, a bulbing room and that on the right a library. The bulbing room is provided with a small entrance lobby to form an air lock, for into the room itself—whilst the operation of bulbing vaccines is in progress—filtered germ-free air is pumped by a centrifugal fan so that a slight positive pres-

sure is maintained, the object aimed at being to minimise the risk of accidental contamination of the vaccines with air-borne organisms.

The Library, in which the Departmental Library and the Records of the Department will be stored, communicates by means of a spiral staircase with the Director's Room above, and with a room below—partly underground—for the storage of chemicals, but which, provided with a carpenter's bench, will also serve as a workshop for the manufacture of various pieces of apparatus.

The main portion of the first floor is given over to a laboratory for reasearch and special investigations. It is equipped with hot and cold incubators (cellular and ordinary) of Hearsen's



Front view of Animal Pockets facing South

Front view of Animal Pockets facing South

manufacture, and the long slate bench on the north side gives ample space for four workers.

Facing the work bench are two rooms built against the south wall, the one for animal inoculations, well lit and equipped with an aseptic operation table and an overhead rail for an electrical surgical motor; and another for the post-mortem examination of experimental animals. This latter room is provided with a powerful gas incinerator by Fletcher, Russel & Co. for the destruction of the cadavers and other infective material.

At the eastern end is the private laboratory of the Director of the Department, which communicates by the winding stairs previously mentioned with the Library below.

At the end opposite to the Director's Laboratory is the room for the preparation of nutrient media. The wall between this and the Research Laboratory is formed by a cupboard and drawer fitment which is available for the use of workers in either room. In the Media Room, too, is placed the large stone reservoir for distilled water. Beyond the Media Room is the Sterilising Room, in which are housed the large autoclave, the steam oven and the hot-air sterilisers, as well as the large sinks for washing up glass ware and their draining shelves.

In the Special Investigation Laboratory, close to the Media Room door, is another door opening on to a flat between the Laboratory and the Orthopædic Workshops, which occupy the upper part of the site of the old Chemical Theatre, and are, consequently, above the glass store, Incubator Rooms and Refrigerator Room of the Bacteriological Department. From the flat a flight of steps ascends to the flat portion of the roof of the Department. On this concrete flat have been erected two animal houses, one with a south-west aspect, for inoculated animals, the other facing north-east, for stock animals. Beneath the ridge of the roof, behind this latter, is a small room for the storage of fodder and sawdust. It also contains the steam-heated apparatus for distilled water which, after condensation, is conducted in tin compo piping to the reservoir in the Media Room below. The animal cages vary in size for different animals, and are constructed in concrete and cemented and provided

with swinging galvanised wire doors. The houses are lighted by electricity, heated by steam pipes and adequately supplied with water. The house for stock animals is closed in with wooden framework and glazed doors, but for the "inoculated" house with its warmer aspect, Japanese reed screens are being tried.

The whole of the constructional work, wood work, heating, lighting, and plumbing has been carried out very efficiently by the Works Department of the Hospital to the plans and designs of the Director. The mosaic flooring of the corridors, the Bulbing, Sterilising, Operating, and Post-mortem Rooms has also been laid by the Works Department, but the wood pulp floors (Decolite) of the remaining rooms and laboratories have been put down by the Bell Asbestos Company.

Appointments.

Civil.

A. J. K. Drew, M.R.C.S., L.R.C.P., to be House-Surgeon, Royal Albert Hospital, Devonport.

C. E. Hicks, M.R.C.S., L.R.C.P., to be Deputy Coroner for the Lughloustorn Division, Hutingdonshire.

C. Jephcott, M.A., M.B., Honorary Medical Officer to the Chester Skin Dispensary.

C. H. Golding-Bird, M.B., F.R.C.S., has been re-elected the Royal College of Surgeons' representative on the Central Midwives' Board for the ensuing year.

Sir Henry Morris, Bt., M.A., M.B., F.R.C.S., was re-elected the Royal College of Surgeons' representative in the General Medical Council.

Royal Army Medical Corps.

C. R. Nicholson, M.R.C.S., L.R.C.P., late Staff Surgeon, R.N., has been appointed temporary Lieutenant, and has proceeded to the British Military Hospital with the Serbian Army.

Capt. T. D. M. Stout, M.S., F.R.C.S., New Zealand Medical Corps, New Zealand Expeditionary Force, Egypt.

Capt. J. Wallace Kemp, R.A.M.C.(T.), 1st London Casualty Clearing Station.

Lieut. Spencer S. Crosse, R.A.M.C., lately on active service in France, now Medical Officer at Segregation Camp, near Devonport.

C. Jephcott, M.A., M.B., to be temporary Civil Surgeon to the Forces at Chester.

Lieut. W. A. Phillips, stationed at the Fort Pitt Military Hospital, Chatham.

Capt. C. E. M. Jones, R.A.M.C. (T.), attached 1/4th Hampshire Regiment, Indian Expeditionary Force D., Bombay.

Lieut. G. B. H. Jones, R.A.M.C. (T.), attached 3/4th Hampshire Regiment, The Castle, Winchester.

To be temporary Lieutenants—Harold Ackroyd, H. W. Fox.

1st Eastern General Hospital:—The undermentioned to be Captain—Wilson Tyson, M.D., B.C., whose services will be available on mobilisation.

Naval.

Fleet-Surg. L. Bidwell, R.N. (retired), to the *Marmora*.

Staff-Surg. F. C. Robinson, R.N., to the *Vivid*.

Surg. W. P. Vicary, R.N., to H.M.S. *Hecla*, c/o G.P.O

Attached to other than Medical Units.

C. H. Laver, 2nd Lieutenant, R.F.A., B. L. Laver, 2nd Lieutenant, R.F.A.

Prob. Flight Sub.-Lieut. R. B. Munday, Royal Naval Flying School, Eastchurch, Sheppey.

To be Lieutenant—F. G. Vicars.

Papers by Guy's Men.

Leslie Doudney, M.R.C.S., L.R.C.P.: Cupping amongst the natives of Northern Nigeria (illustrated).—*Brit. Med. Journ.*, March 20th, 1915.

C. H. Fagge, M.S., F.R.C.S.: Injuries of the semi-lunar cartilages.—*Clin. Journ.*, March 17th, 1915.

P. P. Laidlaw, M.A., B.C.: Some simple anærobic methods.—*Brit. Med. Journ.*, March 20th, 1915.

Ernest J. Maxwell, M.B., B.C., M.R.C.S.; Open-air treatment of typhus fever.—*Ibid.*

J. Reynolds, M.D., and R. J. Reynolds, M.B., B.S.: The prophylactic treatment of puerperal infection by dilute sulphuric acid.—*Lancet*, March 13th, 1915.

Capt. D. P. Watson, R.A.M.C.: The trypanosome causing disease in man in Nyasaland. Part III., Developments in glossina morsitans.—*Journ. Roy. Army Med. Corps*, December, 1914.

BOOKS, ETC., RECEIVED.—The Hospital, The London Hospital Gazette, The St. Mary's Hospital Gazette, The Nursing Times, The Polyclinic, The St. Thomas's Hospital Gazette.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Cases from the Children's Department.

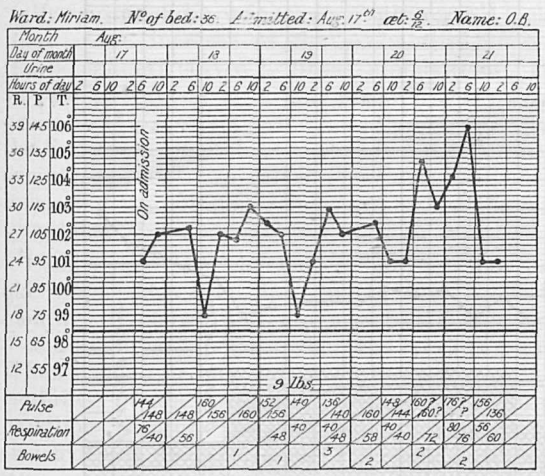
CLINICAL LECTURE BY DR. H. C. CAMERON.

THREE CASES OF ERYSIPELATOUS ŒDEMA IN YOUNG CHILDREN.

GENTLEMEN,—Let me begin by reading to you the following case history:—

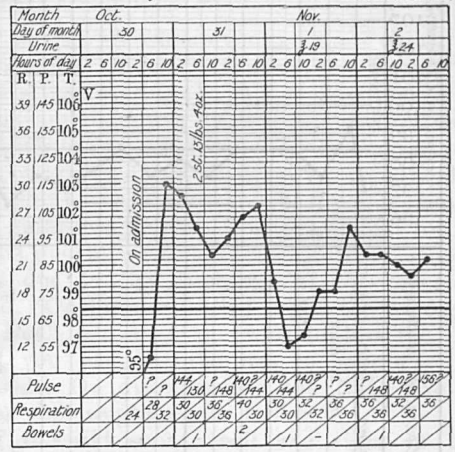
Olive B., aged 6 weeks, admitted August 17th, 1911. The child has been breast-fed from birth and was healthy for the first three weeks of her life. At three weeks she had an abscess of right breast, and at this time the right arm became swollen. This swelling disappeared, but the child remained ill. Some days before admission both legs became œdematous.

On admission.—The child was well nourished, but the lower extremities, vulva, and lower part of abdomen were œdematous, easily pitting on pressure. There was no redness or tenderness. "The general aspect," says the report, "is that of an exceedingly fat baby, but the fat pits on pressure." The abdomen was supple, and palpation did not cause any pain. The right arm was slightly œdematous. The urine contained no albumen or blood; the specific gravity was 1022. The temperature on admission was 101°, and continued high throughout, rising just before death to 106°. Dr. Cameron saw the

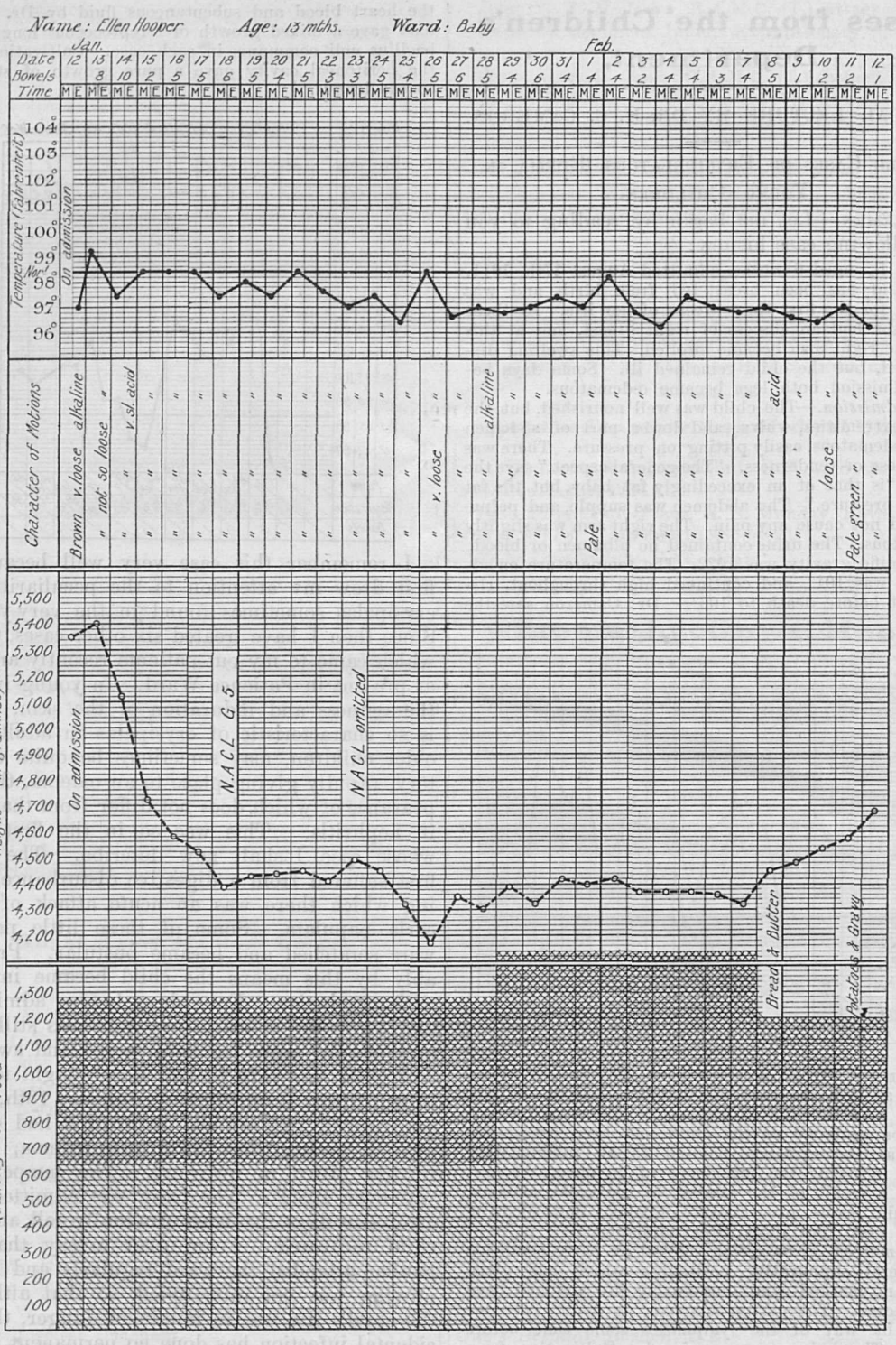


case for Dr. Hertz, and regarded the absence of albumen as evidence that the case was not one of nephritis, and thought an œdema of alimentary origin could be excluded as the child had been breast-fed, and that the evidence pointed to an inflammatory œdema following the subsidence of an attack of erysipelas, a result of the abscess in the right mamma. The child grew progressively weaker, and died on August 21st, four days after admission.

Post-mortem examination showed an early condition of general suppurative peritonitis which had given rise to no marked symptoms during life and had been unsuspected. The peritoneum had, no doubt, been infected by way of the lymphatics some time before death. The kidneys were normal. Cultivation from the heart blood and subcutaneous fluid by Dr. Goodhart gave a mixed growth of streptococcus longus and bacillus coli communis in each case. Cultivation from the peritoneal cavity gave a pure growth of streptococcus longus.



I remember this case very well because it first drew my attention to the peculiarities of erysipelas sometimes found in the very young. Since then I have treated six other cases, two of which came to my out-patients recently and are at present in Patience Ward. In young infants the redness and induration of the skin, which is so characteristic of erysipelas in adults and older children, may sometimes be quite transitory, rapidly giving place to an œdema, the appearance of which does not differ from that seen in nephritis. This was so in the first baby whose case I shall now describe. The child first suffered from a digestive disturbance, during which there was an acute attack of urticaria papulata. Some of these little papules were scratched and became pustular. Presumably by this means the child became infected with erysipelas. Four days before admission, and while the urticaria papulata was still quite marked, the right leg became red and swollen. The child was very ill and was brought to hospital. I saw it on Monday, January 18th, when all trace of redness and induration had disappeared, giving place to a pale œdema, which readily pitted on pressure. The temperature was over 105°F. The baby was admitted and after two days the fever gradually fell and the child recovered. I am glad to say that the mother attended the ward regularly and breast nursing was not interrupted, so that although the child's life was in imminent danger, the accidental infection has done no permanent harm.



The ward chart of a case of alimentary œdema with tetany. The rapid fall in weight was held in check for some time by 5 grams of sodium chloride. The diet consisted of milk (light shading) and barley water (dark shading and 5 % mal sugar.

Three days later I admitted this older child, aged fourteen months, in order to illustrate the point which I am now making. Six days before admission she suffered from what the mother rightly described as erysipelas of both legs. You see now that nothing is left of this erysipelas but œdema involving both legs up to the knee, but, very conveniently for the diagnosis, in this case there is a patch of ordinary unmistakable erysipelas on the right arm at the elbow. This child is older than the others, and in the arm at least the erysipelas is of the usual type seen in adults. The skin is reddened and indurated with a sharp, abrupt, and palpable margin.

I show you these cases that you may be on your guard not to pass them by. The condition is comparatively common and it is not described in the ordinary text-books. The prognosis, apart from the risk of peritonitis or meningitis, is good. Treatment does not influence the attack.

FOUR CASES ILLUSTRATING MANIFEST AND LATENT SPASMOPHILIA.

By spasmophilia we mean a condition in which there is an increase of the excitability of all the peripheral nerves to direct stimulation. If we use galvanism as a stimulus, the increased excitability is directly measurable. Clinically the increased excitability is shown by certain symptoms which are called the *manifest* symptoms and by others which are called *latent* symptoms.

CASE I.—I show you here a baby 12 months old which has been in Clinical for the last month. It shows well the manifest symptoms —tetany, or carpopedal spasm, and laryngismus. When excited or handled (and the increased irritability of the peripheral nerves makes all handling painful), the breathing becomes obstructed and there is a loud stridor on inspiration, reminding one of the inspiratory sound of whooping cough. At first this was more marked, and pinching the child ever so lightly actually produced on more than one occasion a generalised convulsion. The excitability varies from day to day, and when least marked the child relapses almost into a sort of stupor as though the nervous system was exhausted by the violence of the stimuli which had formerly reached it. The hands and feet are held in the typical position of tetany.

Apart from the danger of death from prolonged laryngeal spasm—and this is a very real danger which is the cause of many deaths in infants, for which we are otherwise unable to account—the prognosis is good. This child will recover from the manifest symptoms, although the latent symptoms will persist. Of treatment I shall speak in a minute.

CASE II.—I show you another child, aged 10 months, which, as you see, is suffering from severe malnutrition. When admitted a fortnight ago there was marked cyanosis and œdema of both hands and feet. The œdema, cyanosis, and coldness of the extremities rapidly disappeared. On the large ward chart you see how fast the child lost weight. The loss was far too rapid to be due to wasting in the ordinary sense. It was due to the discharge of the œdematous fluid. On January 18th I began to give 5 grams of NaCl per diem in order to test the point, and you see that the loss in weight at once ceased. On discontinuing the NaCl five days later the weight again fell.

This child shows well two signs of latent tetany, and we may conclude that at any moment manifest tetany may appear. It shows Chvostek's sign. When I tap the malar bone above the canine fossa you notice that there is a twitch of the facial musculature on the same side. It show's Trousseau's sign. When I grasp the arm and press upon the brachial nerve and artery so firmly that the hand again becomes cyanosed, the tetany is once more manifest. Although spasmophilia and œdema following on alimentary disturbances are serious symptoms, I think this child will recover.

NOTE.—The child is now on March 20th in good health, and the rise in weight which has begun to show at the end of the chart has continued uninterruptedly.

CASE III. is an older child, aged 2 years and 6 months. More than a year ago she was in the Sick Children's Infirmary in Glasgow suffering from tetany. Since then she has remained pale and thin and unlike other children. Spasmophilia does not usually give rise to idiocy, but there is no doubt that if severe and persistent, it is followed often enough by neurosis and psychopathic disturbances of all sorts. If you look at this child you will see how strange and unnatural her expression is. It never changes, and she never smiles. In the Babies' Ward we call her the Sphynx. If I take her arm and hold it above her head and then leave go, she continues for minutes at a time in this unnatural posture. She will sit passively in whatever position she is placed, however un-

natural and however uncomfortable. She shows, as you see, Chvostek's sign very markedly. Trousseau's sign is present intermittently. When Dr. Ryffel and I were in the ward one day we produced a spasm of tetany, which lasted for several minutes, but the necessary pressure was painful and the child so manifestly disliked the proceeding that I will not attempt to show the sign.

Case IV.—The last case is a complete contrast. Here is a boy 15 years old who looks about 8 years of age. His height is 4 ft. 1 in., his weight on admission, 3 stone 1 lb. He had severe and persistent spasmophilia in infancy, with pronounced nutritional disturbance, and did not walk or sit up till he was three. Ever since then he has had diarrhœa, with numerous bulky, foul-smelling stools. He shows Chvostek's sign well. He is bright and intelligent. His diet consisted of cow's milk until he was three years old. Since then he has always refused vegetables and has taken only bread, butter, meat, and fish, with tea and milk to drink.

He has had no treatment except that for two years he attended at a neighbouring tuberculin dispensary where tuberculin was injected. I find no evidence of tubercle. His abdomen is a little prominent, but he is otherwise not abnormal in appearance except for the severe degree of infantilism. The epiphyses are normally developed. I show you the X-ray photograph.

Dr. Ryffel has found some interesting abnormalities. The stomach contains no free hydrochloric acid, and the contents are not even acid to Congo red. The urine shows an enormous excess of indican. Cultivations from the fæces show nothing abnormal. On examination with bismuth and X-rays, there is no marked delay in the intestines and the stomach is not dilated. I placed him upon a diet with a large amount of vegetables and with malted milk. In addition, massage and exercises were ordered, with the satisfactory result that in 20 days he has gained nearly 9 lbs. in weight, nearly half a pound a day. This growth is so rapid and satisfactory that we have not yet prescribed the hydrochloric acid which seems indicated. If we had, we might have attributed the success to it.

The treatment of spasmophilia is usually fruitful of good result. The disorder is probably due to a deficiency of calcium salts in the central nervous system, and in many cases estimation has shown that calcium is being passed from the bowel in amounts greater than those taken in with the food. I show you a water-colour sketch of the stool of an infant fed on cow's milk. Such formed solid alkaline stools are not uncommon upon a diet of cow's milk, and they may contain an enormous amount of calcium in combination as phosphate or as soap. Failure to retain calcium is thought to be not uncommon when the diet is composed only of cow's milk. All four cases shown had been fed for a long time exclusively on cow's milk. Upon a diet containing less milk and much carbohydrate in one form or another, improvement in spasmophilia can generally be observed. During manifest spasmophilia, starvation and purgation will generally cut the attack short. Chloral and calcium bromide help to control the symptoms. That the spasmophilia is associated with the disturbances in the distribution of the salts in the body is also suggested by the frequent occurrence of œdema with tetany. We know nothing of any changes in the parathyroid glands. Case I. is now being treated with the dried extract of the gland.

Latent spasmophilia is very common. Of my out-patients about one case in ten of bottle-fed children between eight and eighteen months of age shows Chvostek's or Trousseau's sign. Breast-fed children are seldom, if ever, affected.

Obituary.

Sir GEORGE TURNER,
M.B., D.P.H. Cambridge.

We regret to announce the death of Sir George Turner which occurred at his residence, Colyton, Devon, on March 12th, in his 70th year.

Sir George entered Guy's in 1868 and qualified M.R.C.S., L.R.C.P., in 1872. He took the D.P.H. in 1875, and in that year was appointed Medical Officer of Health and Public Analyst to the Borough and Port of Portsmouth and Physician to the Portsmouth Fever Hospital. He qualified M.B. Cambridge in 1876, and in 1880 became Medical Officer of Health to the Hertfordshire and Essex Combined Sanitary District. He occupied this post for some 15 years, and for the greater part of the time was Lecturer on Hygiene at Guy's and an Examiner in Public Health to the Conjoint Board.

Sir George Turner entered the Civil Service of Cape Colony as Medical Officer of Health in 1895, and for twelve years rendered valuable services to South Africa and the cause of humanity. In 1896 the rin-

derpest broke out in South Africa, and Dr. Koch was at work to discover a cure for this scourge. Dr. Koch left very hurriedly, and, after only three weeks' collaboration, Sir George Turner completed the inoculation work and produced a curative and preventive serum which, however, only gave immunity for three weeks. The researches were continued, and after six months' work he discovered that the simultaneous injection of virus and serum was the most effective remedy. Within a year rinderpest was stamped out of Cape Colony and the Cape Government closed their station. Mr. Cecil Rhodes carried on the preventive inoculation in Rhodesia and Egypt for four months at his own expense. These services saved the Cape Colony Government a considerable amount of money.

On the outbreak of the South African War Sir George was seconded as Sanitary Adviser for service with Lord Roberts in the Transvaal, and Lord Roberts himself bore testimony of the value of his work in preventing the ravages of typhoid.

In 1901 the rinderpest again broke out, and a station was opened at Pretoria for distributing the serum discovered in 1897. In twelve months rinderpest was once more stamped out.

The work which Sir George did for the public health of South Africa was of great and lasting value, but the noblest work of his life was carried out in connection with leprosy. He gave up his spare time to the care of 90 lepers in the asylum at Pretoria, alleviating their suffering and prosecuting a tireless research into the nature of the disease. He retired from the post of Medical Superintendent to the Pretoria Leper Asylum in 1898. A few years later, whilst working in this country, he discovered that he was himself inflicted with the disease which he had set himself to fight. In 1913 he received the honour of knighthood on the King's own initiative.

Sir George frequently visited the hospital to which he was much attached, and all who knew him were proud and fond of him. He attended the Biennial Dinner last year; those who saw him there commented on the fact that his activity of mind and body was a complete contradiction to the "too old at forty" theory.

He was a widower, and leaves four sons, one of whom graduated in medicine at Aberdeen University in 1897.

Author of the Cure and Prevention of Rinderpest (Reports, 1897-98); Rinderpest: its pathology and means used to combat its invasion of South Africa (*South African Medical Journal*, 1897); Report on Transvaal Census, 1904.

At the present time our minds are fixed on the heroism whose theatre is the battle-field. Amidst the clash of bayonets and the boom of cannon men are ready to give their lives for the good of their country. All honour to them! We mourn the loss of one of the heroes of peace, and, had he died unknown and unhonoured, his last undying treasure must have been the goodwill of a lamentable group of sufferers who owed so much to him.

W. E. T.

Dr. Eyre writes:—George Turner, almost unknown, save by name, to the present generation, was a striking personality at Guy's in the early eighties, when he held the post of Lecturer on Public Health.

Big, burly, and brusque, with close-cropped hair and aggressive chin, no one would have suspected that his early medical studies had been interrupted by lung trouble, to be resumed later on at Montepellier, in order to escape the rigours of the English climate. Such, however, was the case, although, when I first knew him, Turner presented more of the physical characteristics of the virile heavyweight than those of the convalescent phthisic.

As a lecturer, none would have accused Turner of polished oratory; all the same he accomplished the difficult task of infusing life into the dry bones of sanitary science. He illustrated his point by anecdotes and racy yarns, broad rather than subtle in their humour, that riveted the attention of his audience; and those Public Health students who tramped with Turner over Hertfordshire Sewage farms and other outlandish places, acquired an extremely liberal education in outdoor M.O.H. work.

In its early days he was a constant visitor to the old Bacteriological Laboratory, and by example and precept did much to stimulate investigation into the applications of the youthful science to the problems of State Medicine, so that the removal of his sphere of activity to South Africa in 1895 left a gap in the laboratory life, which his frequent letters—evidencing though they did the valuable work he was doing on rinderpest—failed to bridge.

After his retirement from the Transvaal Service, which he was always careful to point out was compulsory (for he was still energetic and full of work and had hoped to spend his declining years in charge of the lepers in the Colony), he returned to London, and although a long, flowing grey beard gave him the appearance of a patriach, the man himself was as juvenile as ever.

He lived for a time in Aberdeen, and took out lectures in medicine at the University, but soon he was forced to come south, and then established himself in Devonshire. From here he made frequent pilgrimages to town, and divided his time between the Bacteriological and the Light Departments in search of knowledge and of relief from the disabilities inseparable from his infection. Indeed, he was in the hospital less than a fortnight before the long-forseen end so suddenly overtook him.

Turner did nothing by halves, he was a true and loyal friend and an implacable though generous foe, and his rugged exterior and abrupt manner disguised a very kindly disposition. In all, he was a type of Britain nowadays only too seldom encountered.

Letters from Men on Active Service.

Union Government Transport,
"Galway Castle,"
Cape Town,
Feb. 18th, 1915.

Dear Sir,

After reading Major R. C. Mullins' letter in your issue of January 2nd, it occurs to me that you would like to hear of other Guy's men doing their bit out here.

Major Hamilton, the best qualified man in South Africa, is acting on the staff at Luderitzbucht. He specially desires to be remembered to John (now, you dear thing, don't you be so busy). Liebson is M.O. to the Rand Light Infantry. I had to get out of my bunk at 11 p.m. to admire his uniform. Pat Monaghan, one of the, shall we say most strenuous halves that ever played for Guy's, is doing duty at the Castle in Cape Town. Bill Adams, of the curly locks, has been up to Luderitzbucht with several details, while I hear that Leipoldt did fine work in the rebellion, getting a large experience of dum-dum wounds. I also spent a few hours with Jack Saner's brother who was quite cheery and holds a commission in the I.L.H.

German South-West Africa is truly a ghastly country. A Tommy, writing home, described it as miles and miles and miles and miles and miles of sweet Fanny Adams, which is his emphatic way of expressing nothing but desert. The two towns which we have occupied on the coast, Luderitzbucht and Swakopmund, are known as the havens of Sin, Sand, Sore Eyes, and the Specific S.

If this, sir, is of any interest to you, you are welcome to use it; otherwise consign it to the W.P.B.

Yours truly,
"JAGGERS."

Dispensary and Pharmaceutical Laboratory Report for 1914.

The total number of Out-Patient attendances at the Dispensary during 1914 was 176,973 as compared with 188,238 in 1913, 197,557 in 1912, 220,591 in 1911, 221,847 in 1910, and 203,445 in 1909.

These are classified for the last two years as follows—

NUMBER OF DISPENSARY ATTENDANCES.

1914.	Medical.	Surgical.	Casual.	Total.
Paying ...	61,396	33,290	42,017	136,703
Free ...	11,850	6,843	21,577	40,270
Total ...	73,246	40,133	63,594	176,973
1913.				
Paying ...	66,304	36,449	40,682	143,435
Free ...	13,444	7,309	24,050	44,803
Total ...	79,748	43,758	64,732	188,238

In several annual reports attention has been drawn to the fact that the work of the Dispensary concentrated itself to a very large and dangerous degree in a few hours late in the evening.

Until about ten years ago the Dispensary was open to Out-Patients until 11 p.m. It was then closed at 7 p.m. Under this arrangement patients living in the neighbourhood, instead of obtaining their medicine after seeing the doctor, were accustomed to go home and send their children for medicine later in the evening.

At the beginning of 1914 it was decided by the House-Committee not to allow patients to be re-admitted after 6 p.m. It is impossible to speak too highly of the beneficial result of this on the work of the Dispensary. Whereas formerly the dispenser on late duty had to deal with something like 200 Out-Patients, besides emergency work from the wards, this has now been reduced to about one-third that number.

The receipts have been as follows:—

	1914. £ s. d.	1913. £ s. d.
Out-Patients	1,720 1 0	1,784 18 5
Sale of Drugs	230 8 2	210 3 4
Net Profit on the Sale of Bottles to Out-Patients	81 14 1	80 0 4
Goods supplied to the Medical School	118 10 7	121 8 0
Goods supplied to the Dental School	85 6 1	80 17 10
Goods supplied to the Institution	19 7 2	14 10 1
Medicines and Dressings supplied to the Nursing and Domestic Staff ...	67 19 10	——
Total	£2,323 6 11	£2,291 18 0

Chemicals have have been supplied to the various departments to the value stated below:—

	1914. £ s. d.	1913. £ s. d.
Surgical Skiagraphic Dept. ...	10 0 11	10 5 2
Medical Skiagraphic Dept. ...	16 13 5	41 7 11
Works Dept.	7 17 0	10 2 7
Orthopædic Workshop	14 11 1	11 1 4
Total	£49 2 5	£72 17 0

The decrease in the cost of materials supplied to the Medical Skiagraphic Department is due, to some extent, to the use of purified barium sulphate for X-ray diagnosis, instead of the more expensive bismuth salts.

The cost of Drugs and Dressings during the last two years is given below:—

	1914. £ s. d.	1913. £ s. d.
Drugs	3,986 5 8	3,300 0 0
Dressings	3,059 10 8	3,000 0 0
Total	£7,045 16 4	£6,300 0 3

ANÆSTHETICS.

	Quantity used. 1914.	1913.	Cost. 1914. £ s. d.	1913. £ s. d.
Absolute Alcohol	100 lbs.	76 lbs.	19 7 6	14 8 8
Benzamine Lactate	2 ozs.	5 ozs.	1 2 6	2 2 9
Chloroform	778 lbs.	1,057 lbs.	47 0 4	72 5 0
Cocaine and its Salts	20 ozs.	16 ozs.	4 16 6	7 16 8
Ether	2,576 lbs.	1,792 lbs	210 8 3	82 2 8
Nitrous Oxide	73,000 gals.	40,600 gals.	118 8 9	64 16 6
Novocaine and its Salts	—	—	21 1 1	11 6 4
Stovaine	—	—	0 8 0	0 3 6
Quinine Urea Hydrochloride	—	—	0 13 8	0 9 0
Total			£423 6 7	£255 11 1

The chief feature of the above list is the large reduction in the amount of Chloroform used and a more than corresponding increase in Ether. In 1913 Ether cost 11d. per lb., but in 1914 the price was raised by most makers to 1s. 8¾d. per lb. It may be pointed out that the corresponding price for the brand which was formerly used in the Hospital for so many years was 2s. 3d. per lb., so that we are still saving over £60 per annum on the use of this particular brand. Benzamine Lactate, better known under the names Eucaine and Betacaine, is now made official by inclusion in the new British Pharmacopœia. It shows a marked decline in use, its place being taken by Novocaine and its salts.

ANTISEPTICS.

	Quantity used. 1914.	1913.	Cost. 1914. £ s. d.	1913. £ s. d.
Acid, Boric	29 cwt.	29 cwt.	39 2 10	38 8 6
Acid, Carbolic	20 cwt.	29 cwt.	35 0 0	84 7 0
Chinosol	9 lbs.	14 lbs.	4 0 4	5 14 7
Cresol	516 gals.	566 gals.	37 1 4	45 10 4
Formaldehyde	800 lbs.	1,120 lbs.	15 19 5	21 14 10
Hydrogen Peroxide (20 vols.)	612 gals.	772 gals.	62 4 6	70 6 3
Iodoform	42 lbs.	7 lbs.	22 13 3	4 15 8
Lysol	None bought	445 gals.	—	71 6 2
Mercuric Chloride	112 lbs.	74 lbs.	11 13 4	8 7 9
Do. Tablets	14 lbs.	20 lbs.	1 3 4	1 13 4
Mercuric Iodide	9 lbs.	3 lbs.	5 0 2	3 6 5
Iodine	53 lbs.	49 lbs.	42 2 4	27 17 5
Total			£276 0 10	£383 8 3

Several of these articles were affected by the outbreak of war. As stated below, the German product Lysol was being manufactured in the laboratory. Formaldehyde became unobtainable. Phenol advanced to about five times its normal value, but no suggestion was made that the price should be increased while the contract was running. On the other hand, the suppliers of Hydrogen Peroxide requested permission to raise the price on account of the increased cost of raw materials, but as the figure suggested by this firm was in excess of other quotations, their contract was cancelled and a new one entered into.

The history of Lysol is instructive from an administrative point of view. Introduced in 1895, the price was about 8s. per gallon, at which it remained until 1905, when nearly 1,000 gallons were used per annum. Owing to the introduction of soluble Cresol, made in the laboratory, the price was reduced to 3s. 11d. per gallon. This year it has been possible to manufacture our total requirements of 1,000 gallons at a cost of £37 for cresol, £22 for linseed oil, and £10 for potassium hydroxide, or at the rate of a little over 1s. per gallon for materials.

SERA.	Cost. 1914. £ s. d.	1913. £ s. d.
Anti-Anthrax	4 1 8	6 16 8
„ Colon Bacillus	0 16 6	2 19 3
„ Diphtheria	43 6 0	54 11 2
„ Meningococcus	3 7 6	4 10 6
„ Pneumococcus	0 18 0	0 6 10
„ Streptococcus	40 19 4	17 14 3
„ Tetanus	9 12 0	13 4 0
„ Thyreoidin	0 11 0	0 11 0
Normal Horse	2 12 0	2 16 3
Total	£106 4 0	£103 9 11

DRESSINGS.

	Quantity used.		Cost.					
	1914.	1913.	1914. £	s.	d.	1913. £	s.	d.
Bandages, Crepe	50 doz.	42 doz.	15	2	0	12	12	0
Bandages, Grey	790 gross	1,020 gross	364	19	4	496	9	2
Bandages, White	590 gross	686 gross	296	0	0	444	4	10
Bandage Cloth	31,068 yards	27,846 yards	187	15	2	184	18	10
Cellulose Wadding	112 lbs.	56 lbs.	1	17	4	0	18	8
Felt	45 lbs.	27 lbs.	13	12	0	8	1	7
Felt, Poroplastic	8 lbs.	9 lbs.	1	15	5	2	0	3
Gauze, Double Cyanide	36,432 yards	45,600 yards	100	13	11	129	0	0
Gauze, Grey	28,570 yards	36,432 yards	63	6	3	91	18	0
Gauze, Iodoform	4,800 yards	9,204 yards	18	1	8	35	8	7
Gauze, Ribbon	72 doz.	85 doz.	21	19	9	26	2	9
Holland, Brown	40 rolls	28 rolls	78	5	6	54	0	5
Lint	120 cwt.	123 cwt.	675	11	7	692	17	8
Lint, Boric	26 cwt.	31 cwt.	106	16	9	133	8	8
Moss, Compressed	156 sheets	100 sheets	4	19	0	3	9	3
Strapping, Rubber	27 doz.	49 doz.	32	12	6	54	6	6
Tissue, Wool and Gauze	5 cwt.	7 cwt.	21	13	5	28	13	0
Tissue, Gutta Percha	293 lbs.	540 lbs.	62	8	0	94	19	5
Tow	7 cwt.	6 cwt.	9	11	0	7	8	0
Wool, Absorbent	101 cwt.	120 cwt.	290	19	4	348	16	8
Wool, Grey	36 cwt.	39 cwt.	55	15	8	75	1	6
		Total	£2,423	15	7	£2,924	15	9

In the last annual report a record was made of an alteration in detail in buying the supplies of drugs by contract. Formerly the requirements for the year were estimated on the basis of the amount used in the previous year. The wholesale houses complained that this approximation, when used by many institutions, was not near enough to enable them to guard against their losses from market fluctuations. It was, therefore, decided by the House-Committee to contract in future for definite amounts, and to obtain supplementary tenders if necessary.

I have now to report that, in accordance with the new system then adopted, acceptances were made for the definite quantities stated in the tenders. In the case of articles of small bulk, and not liable to deterioration, it was decided to take the total quantity for the year in one delivery. In the case of bulky articles and those substances liable to deterioration, such as hydrogen peroxide, arrangements were made to order from time to time as required.

One disadvantage of obtaining these unusually large quantities in one consignment was in connection with storage room. Fortunately this is of a temporary nature, since the erection of a new building for the treatment of tuberculosis has provided an excellent basement adjoining the Dispensary Stores.

The advantages of ordering as large quantities as possible are that the clerical work and testing are reduced to a minimum.

Owing to the circumstances detailed above, the outbreak of war found the Hospital with a much greater stock of medical supplies than had ever been the case. Of some articles there was sufficient to last until March. This enabled us to tide over the period of comparatively high prices which occurred, but which is gradually subsiding.

As a rule those contractors who manufactured the articles they supplied have made no attempt to escape from the legal fulfilment of their contracts, but those who are dealers have done so.

It is difficult to know what the legal result would be to attempt to force the delivery, at contract rates, of all the articles quoted for. Some, such as sugar, would entail large losses on the suppliers. In others, the advance in price has been less serious. To quote an example, a contract was made in March for the supply of 3 cwt. of acetylsalicylic acid at 1s. 9¾d. per lb. One hundredweight was supplied at this price, leaving a balance of 2 cwt. to be delivered. This came largely from Germany, and, owing to the stoppage of supplies and the difficulties of improvising the manufacture of it in this country, the price has risen to about 4s. per lb. The presumed loss to the suppliers will be about £20.

In some cases the Hospital has minimised this loss as much as possible, either by recommending prescribers to reduce the consumption, or to employ substitutes. This is illustrated in the case of Liquid Paraffin. This article was formerly refined at Hamburg. When war broke out, the importers informed us that there was no chance of supplying an order for one ton which had been in hand about six weeks. It has been possible to obtain small amounts of a very inferior variety from America, which has been supplemented by the use of an emulsion of the soft variety of paraffin.

The following figures are given to show the large amount spent on certain principal items:—

	Quantity used.		Cost.	
	1914.	1913.	1914.	1913.
			£ s. d.	£ s. d.
Bismuth Salts	287 lbs.	277 lbs.	119 4 5	119 5 6
Camphor	330 lbs.	418 lbs.	24 5 0	33 6 10
Cod Liver Oil	425 gals.	375 gals.	63 8 9	64 13 9
Glycerin	19 cwt.	32 cwt.	88 15 7	146 10 0
Honey	22 cwt.	25½ cwt.	31 6 11	39 1 10
Lard	11½ cwt.	10¾ cwt.	33 8 0	30 14 5
Malt Extract	160 cwt.	160 cwt.	168 0 0	168 0 0
Olive Oil	272 gals.	222½ gals.	57 11 4	64 6 9
Oxygen	——	——	88 0 5	89 13 5
Potassium Iodide	224 lbs.	235 lbs.	125 4 2	116 15 2
Spirit, Methylated	1,440 gals.	1,600 gals.	162 0 0	178 4 8
Do. Rectified	150 gals.	100 gals.	198 2 6	131 5 0
Sugar	90½ cwt.	84 cwt.	77 1 4	75 15 11
Total			£1,236 8 5	£1,257 13 3

PHARMACEUTICAL LABORATORY.

The work of this section has included the following:—

	1914	1913.
Collodions	4 gals.	4½ gals.
Confections	1½ cwt.	2 cwt.
Dentifrices	1 cwt.	1½ cwt.
Liniments	250 gals.	226 gals.
Mixtures	8,160 gals.	8,782 gals.
Ointments	40 cwt.	54 cwt.
Plasters	3,300 yds.	3,840 yds.
Syrups	670 gals.	841 gals.
Tablets (Compressed)	10½ cwt.	11½ cwt.
Tinctures & Liquid Extracts	244 gals.	257 gals.
Soda Water	22,249 syph.	22,395 syph.
Ether Soap	226 gals.	278 gals.

(Signed) H. FINNEMORE, B.Sc., F.I.C.,
February 10th, 1915. Pharmacist to the Hospital.

Guy's Hospital Employees Social Club.

A club, bearing the above name, has been started. The first meeting was held on the 16th inst., when a very enjoyable and successful Whist Drive took place in the Pathological Theatre, Mr. Turner securing the 1st prize, Mr. Saltmarsh the 2nd, while Mr. C. Jones was consoled with the "booby" prize. On this occasion is was decided to hold a General Meeting on the 18th inst., with a view to establishing the Club on a permanent basis.

The chief business before this General Meeting, at which Mr. Saltmarsh occupied the chair, was the election of a Committee, and the following were chosen—Messrs. Beckwith, Chapman, Croucher, Robbins, Saltmarsh, Sutton, and Beale (Secretary, pro tem.). It was left to this Committee to fix a night for the monthly meeting, to draw up a programme for the ensuing year, and to draft rules for the conduct of the club. The Committee will welcome suggestions from any member. A very hearty vote of thanks, proposed by Mr. Robbins and seconded by Mr. Beckwith, gave expression to the members' appreciation of Dr. Laidlaw's kindness in granting the use of the Pathological Theatre for the two meetings. The proceedings terminated with a vote of thanks to the Chairman.

In the past there has been little opportunity for the employees of the Hospital and Medical Schools to meet in social intercourse. The Guy's Hospital Employees Social Club will offer facilities for this purpose, and it is hoped that it will foster goodwill between the employees and thus tend to promote the welfare of the Institution. The Committee earnestly desire all those employees, who are in sympathy with the object of the Club, to become members. The annual subscription has been fixed at 2s. 6d., and the Club has already a membership of 30.

Chapel Notices.

On Monday, Tuesday, Wednesday, and Thursday in Holy Week, Evensong will be said, with a short address, at 8.15 p.m.

On Good Friday the Services will be:—7 a.m., Matins; 9 a.m., Litany; 12-3, The Three Hours' Service, beginning with the Ante-Communion Service; 8.30 p.m., Evensong.

On Easter Eve: 7 a.m., Holy Communion.

On Easter Day: Holy Communion, 6, 7, 8 and 8.45.

The New Guy's Pharmacopœia.

OPHTHALMIC FORMULÆ.

COLLYRIUM ACIDI BORICI, Boric Acid Eye-Wash, is a 2% solution of Boric Acid in sterilised Distilled Water,—approximately 8 grains in 1 fluid ounce.

COLLYRIUM ALKALINUM, Alkaline Eye-Wash.

Take of

Compound Alkaline Powder...	2·2 G. ...	10 gr.
Refined Sugar	1·8 G. ...	8 gr.
Distilled Water to	100 Ml....	1 fl. oz.

Dissolve.

COLLYRIUM BORACIS, Borax Eye-Wash, is a 2% solution of Purified Borax in sterilised Distilled Water,—approximately 8 grains in 1 fluid ounce.

COLLYRIUM HYDRARGYRI PERCHLORIDI, Mercuric Chloride Eye-Wash, is a 1 in 12,000 solution of Mercuric Chloride in sterilised Distilled Water,—approximately 1/24 grain in 1 fluid ounce.

COLLYRIUM ZINCI BORICUM, Boric Acid and Zinc Eye-Wash, is a 2% solution of Boric Acid, and a 0.125% solution of Zinc Sulphate, in sterilised Distilled Water,—approximately 8 grains and ½ grain respectively in 1 fluid ounce.

GUTTÆ ARGENTI NITRATIS, B.P.C., Silver Nitrate Eye-Drops, 0·5%.

GUTTÆ ARGENTI PROTEINATI, Silver Proteinate Eye-Drops, are a 15% solution of Silver Proteinate in sterilised Distilled Water,—approximately 66 grains of Silver Proteinate in 1 fluid ounce.

GUTTÆ ATROPINÆ, Atropine Eye-Drops, are a 0·25% solution of Atropine Sulphate in sterilised Distilled Water,—approximately 1 grain in 1 fluid ounce.

GUTTÆ ATROPINÆ FORTES, Strong Atropine Eye-Drops, are a 1% solution of Atropine Sulphate in sterilised Distilled Water,—approximately 4 grains in 1 fluid ounce.

GUTTÆ ATROPINÆ ET COCAINÆ, B.P.C., Atropine and Cocaine Eye-Drops, are a 1% and 2% solution of Atropine Sulphate and Cocaine Hydrochloride in sterilised Distilled Water,—approximately 4 grains and 8 grains respectively in 1 fluid ounce.

GUTTÆ ATROPINÆ ET HYDRARGYRI PERCHLORIDI, Atropine and Mercuric Chloride Eye-Drops.

Take of

Atropine Sulphate	25 Mg....	1 gr.
Solution of Mercuric Chloride	1·25 Ml. ..	1 fl. dr.
Sterilised Distilled Water to	10 Ml....	1 fl oz.

Dissolve and mix.

GUTTÆ COCAINÆ, B.P.C., Cocaine Eye-Drops, 2%

GUTTÆ CUPRI SULPHATIS, B.P.C., Copper Sulphate Eye-Drops, 0.5%

GUTTÆ ETHYLMORPHINÆ, Ethylmorphine Eye-Drops, are a 1% solution of Ethylmorphine Hydrochloride in sterilised Distilled Water,—approximately 4 grains in 1 fluid ounce.

GUTTÆ ETHYLMORPHINÆ ET COCAINÆ, Ethylmorphine and Cocaine Eye-Drops, are a 1% solution of Ethylmorphine Hydrochloride, and a 1% solution of Cocaine Hydrochloride, in sterilised Distilled Water,—approximately 4 grains each in 1 fluid ounce.

GUTTÆ HOMATROPINÆ, B.P.C., Homatropine Eye-Drops, 1%.

GUTTÆ HOMATROPINÆ ET COCAINÆ, Homatropine and Cocaine Eye-Drops, are a 1% and 2% solution of Homatropine Hydrobromide and Cocaine Hydrochloride in sterilised Distilled Water, approximately 4 grains and 8 grains respectively in 1 fluid ounce.

GUTTÆ HOMATROPINÆ ET COCAINÆ OLEOSÆ, Homatropine and Cocaine Oil.

Take of

Homatropine (1)	1 Dg. ...	4 gr.
Cocaine (2)	2 Dg. ...	8 gr.
Sterilised Castor Oil to (100)	10 Ml. ...	1 fl. oz.

Dissolve.

GUTTÆ HYOSCINÆ, B.P.C., Hyoscine Eye-Drops, 1%

GUTTÆ PHYSOSTIGMINÆ, Physostigmine Eye-Drops, are a 0·125% solution of Physostigmine Sulphate in sterilised Distilled Water,—approximately ½ grain in 1 fluid ounce.

GUTTÆ PHYSOSTIGMINÆ FORTES, Strong Physostigmine Eye-Drops, are a 0·5% solution of Physostigmine Sulphate in sterilised Distilled Water,—approximately 2 grains in 1 fluid ounce.

GUTTÆ PILOCARPINÆ, Pilocarpine Eye-Drops, are a 1% solution of Pilocarpine Nitrate in sterilised Distilled Water,—approximately 4 grains in 1 fluid ounce.

GUTTÆ ZINCI SULPHATIS, Sulphate of Zinc Eye-Drops, are a 0·5% solution of Zinc Sulphate in sterilised Distilled Water,—approximately 2 grains in 1 fluid ounce.

INJECTIO ETHOCAINÆ ET ADRENALINI ANÆSTHETICA, Anæsthetic Injection of Ethocaine and Adrenalin.

Take of

Ethocaine Hydrochloride (2)	2 Dg. ...	8 gr.
Hydrochloride Solution of Adrenalin (1)	1 Dl. ...	5 min.
Sterilised Distilled Water to (100)	10 Ml. ...	1 fl. oz.

Dissolve and mix.

Dose : 4 mils : 1 fluid drachm.

Lamellæ Atropinæ, B.P., Discs of Atropine, contain 0·013 milligram ($\frac{1}{5000}$ grain) of Atropine Sulphate in each.

LAMELLÆ ATROPINÆ FORTES, Strong Atropine Discs, contain 0·65 Mg. ($\frac{1}{100}$ gr.) of Atropine Sulphate in each.

Lamellæ Cocainæ, B.P., Discs of Cocaine, contain 1·3 milligrams ($\frac{1}{50}$ grain) of Cocaine Hydrochloride in each.

Lamellæ Homatropinæ, B.P., Discs of Homatropine, contain 0·65 milligram ($\frac{1}{100}$ grain) of Homatropine Hydrobromide in each.

LAMELLÆ HOMATROPINÆ FORTES, *Strong Homatropine* Discs, contain 1·3 Mg. ($\frac{1}{50}$ gr.) of Homatropine Hydrobromide in each.

LAMELLÆ HOMATROPINÆ ET COCAINÆ, *Homatropine and Cocaine Discs*, contain 1·3 Mg. ($\frac{1}{50}$ gr.) of Homatropine Hydrobromide and 1·3 Mg. ($\frac{1}{50}$ gr.) of Cocaine Hydrochloride in each.

Lamellæ Physostigminæ, B.P., Discs of Physostigmine contain 0·065 milligram ($\frac{1}{1000}$ grain) of Physostigmine Sulphate in each.

OCULENTUM ACIDI BORICI, B.P.C., Boric Acid Eye-Ointment, 4%, contains Boric Acid in white Soft Paraffin,—approximately 16 grains in 1 ounce.

OCULENTUM ATROPINÆ, *Atropine Eye-Ointment*, 0·25%, contains Atropine Sulphate in white Soft Paraffin,—approximately 1 grain in 1 ounce.

OCULENTUM COCAINÆ, *Cocaine Eye-Ointment*, 2%, contains Cocaine Hydrochloride in white Soft Paraffin,—approximately 8 grains in 1 ounce.

OCULENTUM CUPRI SULPHATIS, Copper Sulphate Eye-Ointment, 0·25%, contains Copper Sulphate in white Soft Paraffin,—approximately 1 grain in 1 ounce.

OCULENTUM FLAVUM, B.P.C., Yellow Eye-Ointment, 1%, is made with recently precipitated Yellow Mercuric Oxide, Wool Fat and yellow Soft Paraffin.

OCULENTUM FLAVUM CUM ATROPINA, Yellow Eye-Ointment with Atropine.

Take of		
Atropine (0·50)	5 Cg.	... 2 gr.
Yellow Eye-Ointment to (100)	10 G.	... 1 oz.

Mix.

OCULENTUM IODOFORMI, Iodoform Eye-Ointment, 2%, contains precipitated Iodoform in white Soft Paraffin,—approximately 8 grains in 1 ounce.

OCULENTUM MORPHINÆ, Morphine Eye-Ointment, 1%, contains Morphine Hydrochloride in white Soft Paraffin,—approximately 4 grains in 1 ounce.

OCULENTUM PHYSOSTIGMINÆ, Physostigmine Eye-Ointment, 0·25%, contains Physostigmine Sulphate in white Soft Paraffin,—approximately 1 grain in 1 ounce.

OCULENTUM PHYSOSTIGMINÆ ET MORPHINÆ, Physostigmine and Morphine Eye-Ointment, contains equal weights of Physostigmine and Morphine Eye-Ointment.

OCULENTUM ZINCI SALICYLICUM, *Zinc and Salicylic* Eye-Ointment.

Take of		
Salicylic Acid, in powder ...	6 Dg.	... 10 gr.
Zinc Oxide	5 G.	... 80 gr.
Starch, in powder	10 G.	... 150 gr.
Soft Paraffin, white, to ...	30 G.	... 1 oz.

Mix.

Renal Function in Kidney Disease.

THE various methods that have been proposed for testing the excretory efficiency of diseased kidneys may be divided into the following groups:—

(i.) Foreign substances are given by the mouth or injected subcutaneously or intramuscularly and the rate of elimination is determined. When the substance, such as methylene blue, or phenol-sulphonephthalein, is coloured, these methods have the advantage of simplicity of determination, but they are always open to the criticism that study of the excretion of unusual substances does not necessarily give information as to the functional value of the kidneys.

(ii.) Normal excretory products are studied in a similar manner. The patient is kept on a constant diet for several days, and on one of the days an extra dose of the selected substance is given, say 10 grm. salt, 20 grm. urea, or 1·5 grm. creatinin, and the rate of elimination studied by determining the output of the substance on each day of the series, or, in the case of creatinin, for 6-hourly periods. The method is somewhat laborious and depends for its accuracy on accurate collection of the urine.

(iii.) Determinations are made of the concentration of urea, chloride, etc., in the urine. As what is aimed at is to find out whether the kidneys are incapable of excreting the various substances in reasonable concentration, observations should be made on known diets and repeated several times.

(iv.) Determinations of the electrical conductivity or the lowering of the freezing point of the urine. These really belong to the same category as (iii.) and have the disadvantage that no definite substances are determined.

(v.) Determinations of urea and chloride in blood or blood serum. Chloride estimations may prove to be of considerable value when a sufficiently large number of results, obtained by reliable methods, have been accumulated, but the estimation of urea is probably at present the most valuable single determination that can be made in nephritis.

For this purpose it is possible to use the more specific methods, such as that of Folin or the urease method of Marshall, but the estimation by means of hypobromite elaborated by Widal and his collaborators is sufficiently accurate for clinical purposes and has the advantage that many data have been accumulated by the use of this method. Using the latest modification by Ambard, described below, a determination can be made in half an hour on 10 c.c. of blood, and there is no reason why the apparatus should not be made small enough to allow of the use of only 2 c.c. of blood.

The urea of normal blood so determined varies between 0·15 and 0·50 grm. per 1,000 c.c., depend-

ing on the individual, the time of day, and the time and nature of the last meal. Usually the value is between 0·2 and 0·3, and it is never above 0·4 unless the diet is exceptionally nitrogenous. In nephritis, values ranging from 0·1 to nearly 5·0 are obtained, and here also the values are dependent on the diet. Thus Widal quotes a case which gave the value 1·2 on an ordinary milk diet. This rose to 1·9 when 20 grm. urea were added to the daily diet, and fell to 0·36 on a low nitrogen vegetarian diet.

Acute Nephritis.—Corresponding to an inadequate secretion of urine, the urea of the blood may reach high values, say 2·5, with complete or nearly complete recovery, so that this determination has little bearing on prognosis, though it does serve to indicate the imminence of uræmia. During the attack there is retention of other substances as well as urea, notably chloride. Recovery may be so rapid that the amounts of the various substances excreted for a short period are in obvious excess of what could be produced in metabolism.

Cases of Chronic Nephritis are divided into two main groups, with intermediate cases. In one group the urea of the blood is not above normal and may be as low as 0·1. The rate of excretion of additional urea and creatinin is not markedly different from normal, and there may even be a fair response to diuretics such as caffeine. On the other hand, there is œdema, the urine contains little chloride, and additional chloride given by the mouth causes increase of œdema and little increase of chloride in the urine. The urine may contain much albumen and casts. The blood pressure is not markedly increased, and may be rather low. As there is no difficulty in excreting urea there is no indication for a diet specially poor in nitrogen, but limited chloride in the food appears desirable. The cases do not pass directly from this condition to uræmia, and, when they die from heart failure or from intercurrent infection, they are described as cases of large white, or rather large pale, kidney, in which the tubular tissue is not noticeably below normal, although it often shows marked necrobiotic change.

In the other group there is not usually any œdema and chloride excretion is not markedly inefficient, but the urea of the blood is well above normal and the rate of excretion of additional urea and creatinin is markedly impaired. The urines are always dilute, especially as to urea. Albumen and casts may be small in amount. There is no response to diuretics, such as caffeine. The blood pressure is high. Heart and arteries are hypertrophied, and there is often albuminuric retinitis. The high urea of the blood indicates that a low nitrogen diet should be beneficial. Such a case may live for months with the urea in the blood at about 1·0, but death ultimately occurs in uræmia.

Cases of lardaceous disease of the kidney, long-standing pyelitis with or without calculi, hydronephrosis, and enlarged prostate with resulting damage to the kidney may also show a similar rise in the urea of the blood, and a tendency to uræmia without necessarily showing the vascular changes of the above group.

Uræmia.—In the majority of cases of uræmia the urea of the blood is over 3·0 and may be nearly as high as 5·0, and in all these cases there are marked pathological changes in the kidneys consisting generally of great diminution of effective secretory kidney substance. Typical cases where the urea is high also show hyperpnœa, low alveolar carbon dioxide, and an increased acidity of the blood, so that there is also retention of the excess of acid over base which results from metabolism. Occasionally symptoms of acid retention are met with in older subjects without evidence of urea retention. These are often described as cases of uræmia, but as they do not show extreme changes in the kidneys they are cardio-renal rather than renal.

Dangers of Operation.—Determinations of urea in blood are useful as an index of the risk of bringing on uræmia by operation and by the antidiuretic effect of general anæsthetics, but a septic urinary tract, which is in itself a source of similar risks, is not always accompanied by a raised urea.

The *Yvon-Ambard* apparatus consists of a burette tube of about three-eighths of an inch internal diameter and 15 inches long; $2\frac{1}{4}$ inches from one end is a glass tap dividing the tube into a short limb A and a long limb B. B is graduated in c.c. beginning from the tap, and a rubber bag, about $5\frac{1}{2}$ inches long, the body of which is slightly wider than the burette and contains a few glass beads, is fitted on to the end of B.

Ten c.c., 20 per cent., trichloracetic acid solution are placed in a stoppered 25 c.c. flask; 10 c.c. of blood are then measured from a syringe into the flask and mixed with the acid. Finally, water is added to make the volume up to 25 c.c. and the whole contents are thoroughly mixed. The mixture is then filtered without dilution into a dry cylinder, where it is measured, and phenol phthalein and 10 per cent. caustic soda are added till a pink colour is produced. The apparatus is placed vertically A uppermost, and the liquid transferred to B through A by squeezing and relaxing the bag. The remnants of the solution are washed into B by means of cooled boiled water. The liquid in B is then pushed up to the tap by squeezing the bag. When B and the tap are full of liquid, the tap is closed. Hypobromite solution is placed in A and run into B without admitting air. The contents of B and the bag are thoroughly mixed by repeatedly inverting the apparatus. When no more gas is evolved, the apparatus is transferred to a cylinder of water, the bag is removed and the volume

of gas in B read off when the water is level inside and out. For the calculation, suppose the filtrate measured 15 c.c., then the urea in this is fifteen-twentyfifths of that present in the blood taken (10 c.c.). 0·1 grm. urea yields 37 c.c. nitrogen at 15° C. at atmospheric pressure over water.

J. H. RYFFEL.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

SIR,—On the several occasions since the beginning of December that I have been up to the Hospital I have asked various friends and colleagues to find me an Officer for this Unit, but so far without success.

After my establishment of officers was completed, certain of them left to join the Expeditionary Force, and I am now faced with having to find four more.

I gather that the reason why men join the Special Reserve instead of the Territorial Force is, that they believe they will arrive at the "Front" earlier by doing so; and am told that this is the determining factor rather than the apparently greater pay.

I wish, therefore, to put forward certain points in favour of a Field Ambulance of the T.F. In the first place, it is true that one joining the Special Reserve *may* get out to the "Front" before we do; but, on the other hand, he *may* be kept at home for the whole period of the war; and also he *may* get out with a Territorial Field Ambulance considerably sooner than anyone joining the Special Reserve at present.

In the second place by joining a Field Ambulance he is assured of an open air life during his period of training before he goes, and when he goes he is pretty certain of really getting to the "Front," instead of being left somewhere in France many miles from it.

Thirdly, in addition to myself there are already in this Unit two Guy's men well known to your younger readers, and if there are four men thinking of qualifying at the coming examinations who would like to join together, they might well consider that to join this unit is a suitable opportunity of doing so.

I do not need men of vast experience; freshly qualified men or those who have done one of the new short appointments are very suitable. I do want men who are active, hard, and willing to work.—I am, dear Sir, yours faithfully,

T. B. LAYTON,
Major, R.A.M.C.(T.)
O.C. 24th London Field Ambulance.

Dorking,
March 22nd, 1915.

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of the Published Writings of the late THOMAS BRYANT, F.R.C.S., Hon. M.Ch. R.U.I., Hon. M.D. Dublin, Hon.F.R.C.S.I.

COMPILED BY J. H. E. WINSTON, Wills Librarian.

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Presidential address to the Royal Med. Chir. Soc., *Trans. Med. Chir. Soc.*, 1899, lxxxii., ci.-cxxvi.

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1901.

Urinary calculi formed upon pubic hairs, *Trans. Path. Soc.*, 1901, lii., 163.

1902.

An analysis of forty-six cases of cancer of the breast which have been operated upon and survived the operation from 5 to 32 years, with remarks upon the treatment of recurrent growths, including the disease of the second breast, operative and otherwise, *Brit. Med. Jour.*, 1902, i., 1200-1203, and *Med. Chir. Trans.*, 1902, lxxv., 43-68.

Case of displaced strangulated femoral hernia in which the sac with its contents was displaced downwards and inwards, through an opening at the lower end of the femoral sheath, in front of the adductor muscles, on the inner side of Scarpa's triangle, *Clin. Soc. Trans.*, 1902, xxxv., 3-6.

Case of intestinal obstruction due to the pressure of a vesical sacculus upon a coil of small intestine, *Med. Chir. Trans.*, 1902, lxxxv., 37-42.

Birth.

DRYLAND.—To Mr. and Mrs. P. Winter Dryland a daughter, on February 23rd.

Marriage.

POOLE—MARCHBANK.—On Wednesday, March 17th, at the Westgate Road Baptist Church, Newcastle-on-Tyne, by the Rev. T. J. Whitman, assisted by the Rev. S. V. Marchbank (brother of bride), Stuart Kingsley Poole, of Thanet House, Cresswell, only son of M. J. Poole, J.P., and Mrs. Poole, of Ramsgate, to Elizabeth Viccars Marchbank, fifth daughter of the late J. Marchbank and Mrs. Marchbank, of 31, Grove Street, Newcastle-on-Tyne.

Death.

KENT.—At Tong Shan, North China, on February 19th, Anthony Lloyd (Tony), the younger son of Dr. and Mrs. Hugh Kent, aged one year.

W. E. T.

GUY'S HOSPITAL GAZETTE.

VOL. XXIX., No. 699.] APRIL 10, 1915. [SIXPENCE.

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Passim.

WE offer our hearty congratulations to Dr. Frederick Taylor, who has been appointed President of the Royal College of Physicians. The election took place, according to the statutes, on the day following Palm Sunday. Dr. Taylor is a graduate of London University, and took the degree of M.D. in 1876. He became Fellow of the College in 1879, was an examiner at various periods from 1885 to 1896, was on the Council from 1897 to 1899, and was Censor in 1904, 1905 and 1910. He has been the representative of the College on the Senate of London University since 1907. He gave the Lumleian Lectures in 1904 on "Some Disorders of the Spleen," and was Harveian Orator in 1907. Last year he was elected President of the Medical Section of the Royal Society of Medicine.

The last Guy's man to be President of the Royal College of Physicians was Sir Samuel Wilks, who held this distinguished post from 1896 to 1899.

The following interesting account of the Presidency of the Royal College of Physicians is taken from the *British Medical Journal*.—

"The Royal College of Physicians of London has had ninety-seven presidents since Henry VIII., in the tenth year of his reign, granted a charter of incorporation. In granting this charter he said that his main reason was to check men who professed physic rather from avarice than in good faith, to the damage of credulous people; accordingly, after the example of other nations he had determined to found a college of the learned men who practised physic in London, in the hope that ignorant and rash practitioners might be restrained or punished. The Charter was granted to John Chamber, Thomas Linacre, Wolsey Archbishop of York, and others. The College so constituted first exercised its privilege of electing a President by choosing Thomas Linacre for that office in 1518. Down to 1876, when Sir George Burrows ceased to be president and was succeeded by Sir James Risdon Bennett, a graduate of Edinburgh, the president had always been a graduate of Cambridge or Oxford. Since the spell was broken the presidents have all been graduates of the University of London, with the exception of Sir Andrew Clark, who was a graduate of Aberdeen, and Sir William Church, a graduate of Oxford."

DR. JOSEPH BARCROFT, F.R.S., will deliver the Oliver-Sharpey Lectures on Tuesday, April 13th, and Thursday, April 15th, at 5 o'clock, at the College, Pall Mall East. The subject is "A Comparison between some Physiological and Pathological Conditions."

DR. BIRDWOOD, an old Guy's man, who qualified M.R.C.S. in 1877, M.B. Cambridge in 1887,

and M D. in 1889, has just retired from the post of Medical Superintendent of the Park Hospital, Hither Green, after 37 years service under the Metropolitan Asylums Board. He has been responsible for many reforms in the working of the service. He carried out the scheme by which small-pox patients were taken direct from their homes to ships moored down river, and he initiated diet scales which have resulted not only in a lessened mortality, but also in a decrease of expenditure. His views were not always supported, but experience proved to be on his side.

Lieut.-Colonel Ferdinand C. Batchelor asks us to correct the statement which appeared in our columns that he "recently arrived in England." He is in Egypt as Consulting Surgeon to the New Zealand Division Expeditionary Force.

Mr. J. G. Saner, Resident Surgical Officer, is spending a well-earned month's holiday in Belgium as operating surgeon to the Belgian Field Hospital; Mr. Bromley is acting Resident Surgical Officer.

The Coolidge X-Ray tube purchased by the Hospital recently is proving a great success.

OVERHEARD IN JOHN WARD.

"I 'ad the X-Rays this morning."

"Did yer!"

"Yus. Wonderful what these doctors can do now, ain't it?" They couldn't do a year ago what they are doing now."

"I suppose it's like this: as they get more civilised the more they get to know."

"That's it."

As a result of the increasing and imperative demands of the Military Authorities, the London, Brighton and South Coast Railway have temporarily suspended the issue of cheap tickets between London Bridge and Honor Oak Park to members of the Clubs' Union.

The Annual "Whole Day" Working Party of the Nurses' Missionary League was held at Guy's Hospital on Friday, March 26th, 1915, from 9 a.m. to 9 p.m. Not only were Guy's members present, but nurses came from the London, St. Bartholomew, Lee District and Camberwell Territorial Hospitals to help. During the day Dr. Blackett and Miss Clifford gave very interesting accounts of their work in India.

Many useful articles were made, including four overalls, 24 eye bandages, also eye shades and pads, over 400 bandages of various sorts, mufflers, slippers and stockings. These will be sent to the C.M.S. Hospital, Hing Hwa, Fah Kien China, on the staff of which are Dr. Ronald Walker, Mrs. Walker (*née* Kirby), and Miss Krause, all of whom come from Guy's. Miss Richardson very kindly gave up the whole day, and helped to superintend the arrangements.

We regret to announce the death of Dr. Edward Francis Herman Hardenberg, which took place at Watford where he was in practice. Dr. Hardenberg qualified in 1894, and was House Surgeon to Sir H. G. Howse. He took the M.B. London with Honours in Forensic Medicine in 1895. An obituary notice is published in this issue.

Will those gentlemen who intend to subscribe towards the Flint Fund kindly do so before Saturday, 17th inst. Contributions, however small, will be gratefully received, and should be sent to the Secretary of the Dental Society, W. J. Rousseau Viljoen, at the Hospital.

Papers by Guy's Men.

W. Stanley George, M.B., B.S., and Alan H. Todd, M.S., F.R.C.S.: Myeloid Sarcoma of the Femur, with pathological fracture.—*Brit. Med. Journ.*, April 3, 1915.

E. C. B. Ibotson, M.D., B.S.: The Ancestry of Ehrlich.—*Lancet*, May 27, 1915.

A. H. Miller, M.A,, M.D.: Further Observations on Sperm Oil Tubercle Bacilli: Their biological significance.—*Lancet*, April 3, 1915.

W. B. Secretan, M.B., F.R.C.S.: Bursting Golf Balls.—*Brit. Med. Journ.*, March 27, 1915.

Bullets and Bacilli.

From the windows of the little inn where I write comes the gleam of a country white with snow, and gathered round the stove, filled with blazing logs, sit a motley crowd of officers, pedlars, and countrymen, sipping *thé á la russe* and drying their feet before the hearth. Looking out thro' the smoky panes one can see in dim outline the hills encircling the little town, which lies at their foot in a cup-like hollow; behind them, rising higher yet are the distant peaks of the Tsenagora, frowning and ominous, a fitting gateway to a land of harsh and arid rocks, for behind is Montenegro. For days I have been travelling through a country, fallow and rich: moving in the easy stages which teach patience to the pampered Westerner. Crawling at a snail's pace through land half submerged in the spring floods, waiting for hours at benighted wayside halts, sleeping by nights in empty compartments in junction sidings, one's travels are to be reckoned in terms of weeks rather than days or hours. The carriages crammed to over-flowing with a jostling crowd of soldiers, women, and children, refugees from typhus-stricken districts, reek with an odour that leaves the sense of smell bewildered. The compleat traveller brings with him sleeping and washing gear, disinfectants, candles, a cooking stove, and food for several days. Among minor necessaries one may count a screwdriver to remove the screws with which every practicable window is hermetically sealed, for according to the Serb fresh air is the *fons et origo malis*. "Your train is a closed box," expostulated an angry traveller the other day. "*Dobro, gospodine*," replied the conductor, regarding this as a compliment to the precautions taken by the Government to keep out the cold. In such an atmosphere microbes multiply and flourish, it seems almost a miracle that the Serbian race has survived so long.

In the market place this morning I came upon a singular procession; a string of some hundred bullock wagons, each drawn by two beasts, and accompanied by a lusty Albanian driver, was setting forth solemnly through the mud and slush. Peering through the wicker curtains one saw within each two or more large crates, unmistakably English, each bearing upon its side the immemorial red cross. It was the St. John's Ambulance party to Montenegro. Already they have been seven weeks upon the way, at a moderate estimate they will be three more, trekking at ten mile stages through bogs and mountains, sleeping at native inns—and only those who have ever slept amid the varied occupants of a village inn know what this can mean—in the wagons, heaven knows where. I hope they arrive—some day, they deserve to; at all events I wish them the best of luck.

I am just completing a fairly extensive tour through the Typhus districts of Serbia, in a few days I shall be back again amid the luxuries of an English hospital with its baths and beds upon which one can sleep without swelling the fortune of Mr. Keating. The English passion for washing strikes the Serb as a phenomenon of never failing interest. This morning an appreciative audience of the stable boy and the boots watched my ablutions in a bucket of corrosive sublimate; my room mate, a sergeant of the Nisch constabulary, has never washed since I have known him, and we nearly came to blows over the question of the open window.

For the realist in search of a subject I recommend a Typhus hospital; imagine, if you can, a blend of all the stenches in the gamut of human experience, picture human beings reduced to the utmost limits of despair and degradation, think of such filth, neglect, insanitation, that the foulest Dublin slum takes on the qualities of a fairy city, multiply the sum total of your conception by ten, and you have, perhaps, an idea of what one sees here day after day, till the sight loses its original horror in a litany of sameness. Ward after ward that one passes through, stable after stable, garret upon garret, are a repetition of the same. In each, long rows of figures, haggard almost beyond the semblance of humanity, some raving in the tortures of delirium, some in twisted shapes, still, their upturned pupils staring out into the great beyond, some sitting half upright shrouded in the muddy grey uniforms that seem almost an emblem of woe, moaning and nursing their sores; huddled upon the straw their heads on boots, covered with their overcoats and a few sacks, these lazar houses are but a shambles where men come before they die.

The few attendants, Austrian prisoners for the most part as indeed are the majority of the sick, minister as best they can to the needs of the patients, till they too succumb under the strain. I have to-day visited the Infantry barracks, now the largest fever hospital in the town; in it there were some 650 patients suffering from typhus, typhoid, enteric, and dysentery. The medical staff is composed of two doctors, an Austrian alienist, taken prisoner, and a Russian lady doctor. Naturally enough they are utterly unable to cope with the work and the few orderlies who so far have withstood the combined attacks of disease and starvation, are compelled to spend most of their time in putting back to bed patients who have collapsed on their way to the conveniences. The whole place stank of fæces and stale urine. The sanitary arrangements seemed calculated rather to favour the spread of disease than prevent it. In the wards the patients lie huddled close to each other for the sake of warmth, covered with a few old sacks or straw, their heads pillowed on boots or the day's loaf. Many too weak to move are covered in their own excreta.

In the hall below a motley crowd of soldiers stand, shouting and fighting, a few bandaged, the rest covering their wounds as best they can with the tattered remnants of their uniforms. Few have any complete article of clothing, many have discarded all semblance of military attire except the regulation *Képis;* nearly all, however,

cling jealously to their rifles, and the effect is cut-throat to say the least. These are all men who have come direct from the front on foot, or in bullock wagons, and are waiting for treatment in this improvised out-patient department. On the way, our cab pitching and jostling through snow-drifts and potholes, the commandant explains his difficultles—the lack of medical organization, the appalling number of doctors who have died in the epidemic, already this is 72, the need of supplies and willing helpers. "If England—he said—would only send us sheets, clothing and boots, and men and women who are willing and able to work and take the grave risks which they will have to face, she will be doing a greater service to Serbia than in sending her money which she cannot spend, and guns and ammunition which she has no men to use." And as the deaths from typhus are anything from 1,000 to 1,500 a day, he was probably right.

But, from amid this squalor and misery, one has a lasting impression of a people simple, kindly, courageous, retaining after five hundred years of Turkish and Austrian oppression the qualities which made a traveller exclaim to me the other day—"They are a nation of gentlemen!" Since 1912 they have been engaged in three wars, and have lost 160,000 men of fighting age out of a population of about six million. And now a foe is among them against whom their bravery is of no avail, and the men in whose land no invader could find a foothold now lie stricken as by the hand of God. For deadlier far than the Austrian bullet is the Typhus bacillus. G. H. F. G.

Uziér, Serbia,
March 10th, 1915.

Change of Address.

G. W. E. Holloway, 3, Oakland Road, Dovercourt Bay.

Capt. E. H. Musgrove, Brecknock Battalion, South Wales Borderers, Aden, Arabia. On active service.

A. J. Reynolds, 112, Regent Road, Great Yarmouth.

Lieut. C. R. Nicholson, R.A.M.C., British Military Hospital, attached to Serbian Army, Serbia (temporary).

(The Editor will be very glad to receive a post card with notes of any change of address.)

Pass List.

Society of Apothecaries.

At examinations held recently the following candidates were successful:—

Surgery.—L. A. J. Graham, R. A. Holmes.
Medicine.—R. A. Holmes.

The Diploma of the Society was granted to the following candidate:—

R. A. Holmes.

Letters from Men on Active Service.

No. 6, Indian General Hospital,
I.E.F. "B,"
British East Africa,
c/o India Office, London,

Dear Mr. Editor,

I have just received a batch of Gazettes in one of which you ask for the names of Guy's men who are serving with the Colours.

I believe I am the only Guy's man who came out with the Indian Expeditionary Force to this country, but Capt. Watts, I.M.S., is doing duty on the Hospital ship *Madras*, which has been taking patients back to India from here and from the Persian Gulf. I saw him in Mombasa in December, and he took me over the *Madras* which is most beautifully fitted up.

I have seen three other Guy's men out here, all of whom are in the East African Medical Service—Collar, Dunderdale, and Williams. Collar was looking after 1,000 African natives—a "Carrier Corps." Dunderdale is stationed at Larnu, on the Coast—I had dinner with him and his wife at Mombasa.—Williams (the famous "Fluffy Bill") is at Voi, which is on the Uganda Railway between Mombasa and Nairobi. H. L. Duke and Marshall are in Uganda, but I have not seen them.

Unfortunately there is a strict censorship out here, and one is not allowed to write any acount of the fighting, or even to put one's address on one's letters or the date. Personally I have not been under fire, though I watched one of our cruisers bombarding Tanga and the landing (and subsequent re-embarkation) of our troops at that unholy spot.

For a short time I was in medical charge of some German prisoners on a boat in Mombasa Harbour, but since then I have been with this Hospital up country. I have met here an old Guy's Sister in the person of Miss Atkey (late Sister Addison), who is Matron of the European Hospital here.

The difficulties of a campaign out here are very great, owing to the great shortage of water, and the prevalence of malaria which is almost exclusively of the "malignant" type. There is also a certain amount of dysentery and African tick fever. For the latter we are having very good results from Neo Salvarsan. Another plague in this country is the "Jigger," which causes the most horrible ulceration unless it is spotted and extracted at once.

Here we are practically on the Equator, and though we are 6,000 feet above sea level the sun is very hot in the middle of the day. Until yesterday we had had no mail from England for six weeks and the good old Gazettes were therefore even more welcome than usual.

If this should meet the eye of Philip Smith and Jamie Stewart, here's to our next merry meeting. But it is sad to think of the gap in our little band of externs. It may interest some Guy's men to know that Captain A. H. Fyffe, R.A.M.C. is out here and is at present in charge of the European Hospital. He was at Thomas' and knew Bromley, Lee, and the Saners.

Heale, the famous London "half" is also out here in the R.A.M.C. He is unfortunately in hospital with relapsing fever at present.

Here's the best of luck to dear old Guy's and to all my old pals in France.

Yours faithfully,
GORDON COVELL, I.M.S.

H.M.S. *Warrior*.
March 30,

My Dear Tanner,

I don't see any letter in your paper from the Silent Navy, so I write a line to tell you what we are doing, or rather not doing; indeed, you could hardly publish this as from one on active service. I am one of the temporary surgeons who is doing nothing for his country under somewhat trying conditions. Well, a sample days work is as follows:—

8.30. I get out of my bunk swearing as naturally as a baby is born crying, dress and breakfast; this takes an hour, by the Grace of Heaven.

9.0. Morning rounds; a few sore throats; my two colleagues examine them exhaustively, I shave and breakfast.

9.30–12. I walk the Quarter Deck—"plank-squeezing," it is called. To the South is unbroken sea and the other quarters of the compass is also sea. I generate what they call a bogus appetite which does its worst at

12.0. Lunch; I then go to the Quarter Deck and walk till a siesta is indicated, then

3.30. Tea. I walk the Quarter Deck afterwards till

5.0. Censoring. Amusing often, it takes an hour generally.

6.0–7.30. I go and stroll upon the Quarter Deck, dipping occasionally for a chat in the ward room.

7.30. Dinner.

8.30. My day's work begins in grim earnest. I go to the sick bay, and for sometimes as much as ten minutes at a stretch try and spread an atmosphere of cheeriness and health. Only a few days ago there were a couple of men with hypernormal thermogenesis; indeed, I now look upon the least deadly forms of cut finger without much misgiving. I try to school myself to look upon suffering bravely and to keep a cheery face, though I know many a poor fellow may have to wear a bit of plaster or an H.B.F. for a day or two. But it is hard. Then only the other day I saw a tonsil bearing almost certain signs of early inflammation. However, I do believe that my refusal to be overwhelmed helped —where am I? Oh, yes—

8.40. Day's work over; rest and recreation; quarter deck, quarter deck, and—for a variation—the quarter deck.

And yet, my dear Mr. Editor, life has its points—hard work, you may say—but the well-earned gin and general not unhealthy surroundings.

Yours sincerely,
F. GILBERT SCOTT.

Vignettes from France.

VI.

The officers of the regiment were busily engaged in the serious business of breakfast, and were sitting on two heaps of stones as being the dryest place visible. It was cold for the time of year and had been raining steadily for the last day, which meant that they were all very wet as they had been sleeping in the shelter of a hay-stack, there being no billets available on their line of march.

Now they were settling themselves to breakfast of bully beef and bread, washed down with water, while they eagerly discussed the question of the rumours which had been floating about for the last few days. Every regiment they met seeming to have something fresh or something to add to what they already knew.

"If that really is true about the Russians," said a very unshaven major, "we ought to be able to do some good soon." "I heard that one of the new draft had seen them," said the junior subaltern. "There really must be something in it, we've heard it now for so long," said a little captain. As he spoke the captain reached for a tin of bully beef and slowly proceeded to open it with the aid of the key. "After all," he continued, "it isn't as if we had only heard it from one or two sources, it started on the retreat and we've heard it almost every day since then." "I can't say I believe it," said the major with an air of finality—he was always pessimistically inclined in the mornings.

It was hard to keep up one's spirits in the face of this, and the little captain having taken the top off his bully beef tin, inverted it and moodily knocked at the bottom of the tin with his knife. After several knocks, the beef still remaining in the tin, he opened the knife, loosened the edges, and turned it upside down once again. "Anyway," he said, "I came across an Intelligence man yesterday, who said he had himself seen a Russian Officer, and he ought to know." With that he gave the bottom of the tin a vicious prod, and the beef came out with a rush. It balanced on his knees for a second while he made a dive, eluded his grasp, and dropped into a muddy pool of water at the bottom of the stone heap on which he was sitting. He leaned forward and picked it up, annoyed at his carelessness, and after scraping some of the more obvious mud from its sides, he cut off a large slice and commenced his breakfast.

Guy's Hospital.

Tables showing the Cost of Maintenance of the Electrical and Actinotherapeutic Department, the Medical Radiographic, the Surgical Radiographic, the Photographic Departments, and the Massage Department for 1914.

ELECTRICAL AND ACTINOTHERAPEUTIC DEPARTMENT.

Year.	Number of Patients and Treatments.	Apparatus and Tubes.	Repairs and General Sundries.	Salaries.	Current.	Total.	Receipts from Patients, etc.
		£	£	£	£	£	£
1910	1,206 43,731	134	119	450	38	741	131
1911	1,405 49,782	100	68	445	25	638	98
		Ap. Tbs.					
1912	1,539 48,871	£54 £38	57	451	24	624	83
1913	1,401 40,130	£5 £40	93	446	28	612	29
1914	1,439 32,518	£14 £25	63	461	29	592	32

Under Salaries are included payments made to the Physician and Surgeon in charge of the Departments, the Electrician, the Sister in charge of the Light Department, the Staff Nurse, eight Probationers, and a Wardmaid. The Board and Uniform of the Nursing and Domestic Staff are not included.

MEDICAL RADIOGRAPHIC DEPARTMENT.

Year.	Apparatus.	Repairs and General Sundries.	Photographic Materials.	Development of Plates.	Cleaning.	Honour of Radiographer.	Current.	Total.
	£	£	£	£	£	£	s. d.	£
1910	15	8	39	54	1	100	6 10	213
1911	18	18	64	—	£1 10s.	100	11 6	202
1912	44	32	80	—	£3 5s.	100	5 0	260
1913	8	26	76	—	£3 5s.	—	11 0	114
	Ap. Tbs.							
1914	£4 £33	15	53	—	£3 5s.	—	5 0	109

SURGICAL RADIOGRAPHIC DEPARTMENT.

Year.	Apparatus and Tubes.	Repairs and General Sundries.	Photographic Materials.	Cleaning.	Honour of Radiographers.	Current.	Total.
	£	£	£	£	£	£ s. d.	£
1910	344	38	175	1	250	0 17 6	809
1911	127	33	255	2	250	1 1 6	668
	Ap. Tbs.						
1912	£358 £99	35	197	£3 5s.	254	0 12 6	947
1913	£13 £163	46	154	£3 5s.	228	0 11 7	608
1914	£11 £72	6	132	£3 5s.	150	4 9 8	379

PHOTOGRAPHIC DEPARTMENT.

Year.	Number of Patients Photographed.	Plates, etc.	Chemicals.	Cleaning.	Salary of Photographers.	Total.
		£	£	£	£	£
1910	265	11	17	1	117	146
1911	331	14	43	3	145	205
1912	211	17	63	—	180	260
1913	218	36	52	—	189	277
1914	226	33	27	—	200	260

MEDICAL SKIAGRAPHIC DEPARTMENT.

(and Work done for Physicians in Surgical Skiagraphic Department).

In-Patients.		Out-Patients.		Cost of Plates.	Cost of Paper.	Total.
Screened.	Skiagraphed.	Screened.	Skiagraphed.			
				£ s. d.	£ s. d.	£ s. d.
1,757	414	553	172	49 12 0	2 8 10	52 0 10

SURGICAL RADIOGRAPHIC DEPARTMENT.

					£ s. d.	£ s. d.	£ s. d.
Sir Arbuthnot Lane ...	34	188	1	—	10 6 9	0 3 11	10 10 8
Mr. Dunn	109	222	—	—	11 11 10	—	11 11 10
Sir Alfred Fripp ...	42	137	—	—	7 2 8	0 0 4	7 3 0
Mr. Steward	83	204	—	—	10 15 0	0 8 9	11 3 9
Mr. Fagge	62	44	—	13	3 4 1	0 5 1	3 9 2
Mr. Rowlands	33	50	6	15	3 7 6	0 3 5	3 10 11
Mr. Turner	19	25	4	13	1 11 5	0 3 8	1 15 1
Mr. Hughes	44	52	-	—	2 14 2	0 1 6	2 15 8
Mr. Davies-Colley ...	12	17	1	14	1 9 5	0 4 0	1 13 5
Specialists	18	54	47	76	10 7 9	7 1 9	17 9 6
Surgery	1	—	3,327	949	45 18 3	—	45 18 3
Dental Department ..	—	—	—	11	0 6 8	—	0 6 8
Bright Ward	—	15	—	—	1 7 10	0 0 8	1 8 6
Officers' Section... ...	11	36	—	—	2 10 7	0 18 0	3 8 7
	468	1,044	3,386	1,091	£112 13 11	£9 11 1	£122 5 0

MEDICAL SKIAGRAPHIC DEPARTMENT (ANALYSED).

	In-Patients.		Out-Patients.		Cost of Plates.	Cost of Paper.	Total.
	Screened.	Skiag.	Screened.	Skiag.	£ s. d.	£ s. d.	£ s. d.
Sir Cooper Perry (Feb. & Mar.)...	1	1	—	—	0 4 3	—	0 4 3
Dr. Hale White	5	5	—	—	0 5 3	—	0 5 3
Dr. Shaw	1	4	—	—	0 4 9	—	0 4 9
Dr. Fawcett	2	5	—	—	0 11 3	—	0 11 3
Dr. Beddard	—	1	—	—	0 2 6	—	0 2 6
Dr. French	—	2	—	—	0 2 7	—	0 2 7
Dr. Hertz	2	—	—	1	0 2 2	0 1 2	0 3 4
Dr. Cameron	—	4	—	2	0 5 7	0 2 3	0 7 10
Dr. Pitt	—	1	—	—	0 0 10	—	0 0 10
Mr. Heaton	—	—	—	—	—	0 0 3	0 0 3
"Medical Cases"	—	1	—	—	1 4 10	—	1 4 10
Medical Skiagraphic Department	1746	390	553	169	46 8 0	2 5 2	48 13 2
	1757	414	553	172	£49 12 0	£2 8 10	£52 0 10

SPECIALISTS (ANALYSED).

	In-Patients,		Out-Patients.		Cost of Plates.	Cost of Paper.	Total.
	Screened.	Skiag.	Screened.	Skiag.	£ s. d.	£ s. d.	£ s. d.
Mr. Eason	—	2	—	—	0 6 11	—	0 6 11
Mr. Ormond	—	4	—	—	0 3 2	—	0 3 2
Mr. B. Smith...	2	5	—	—	1 1 2	—	1 1 2
Mr. Chapple	2	5	—	2	1 3 0	0 3 5	1 6 5
Mr. Mollison	—	—	1	3	0 6 0	0 0 8	0 6 8
Mr. Layton	2	3	—	—	0 3 0	—	0 3 0
Mr. Thompson	7	13	1	1	1 2 9	0 2 1	1 4 10
Mr. Trethowan	4	11	40	68	4 8 3	0 15 1	5 3 4
Dr. Eyre	—	1	3	2	0 3 3	0 1 9	0 5 0
Dr. Iredell	—	—	—	—	—	0 0 5	0 0 5
R. S. O.	1	—	2	—	0 0 4	0 6 0	0 6 4
Mr. Todd	—	1	—	—	0 1 9	0 0 6	0 2 3
Mr. Shenton	—	9	—	—	1 8 3	5 3 9	6 12 0
Mr. Eccles	—	—	—	—	—	0 7 8	0 7 8
Mr. Attwater (Bac. Lab.) ...	—	—	—	—	—	0 0 4	0 0 4
	18	54	47	76	£10 7 10	£7 1 8	£17 9 6

MASSAGE DEPARTMENT.

Year.	Number of Cases.		Cleaning.	Salaries.	Total.
			£	£	£
1910	827		4	31	35
1911	959		4	31	35
1912	595		4	37	41
		Treatments.			
1913	580	5,389	4	49	53
1914	697	8,862	4	54	58

In December, 1914, the Massage Department was re-organized, and non-resident pupils were admitted, the lengthening of the Curriculum of the Incorporated Society of Trained Masseuses having rendered it impracticable for a Probationer to qualify for the Examination during her three years at Guy's without unduly trenching upon her ordinary training in Medical, Surgical, and Special Nursing.

The re-organized department was placed under the supervision of a specially qualified Sister, associated with a Staff Nurse. Work was begun with five pupils, three non-residents paying ten guineas for the six months' instruction, and two hospital nurses, who pay no fees, but receive no salary, and are retained for six months beyond the three years for which they entered, so as to make up their full general training. There are also ten nurses, already qualified masseuses, doing a certain number of cases in the wards.

At the present time (March, 1915), about 130 patients are receiving systematic massage, the treatments averaging 1,300 a month

Gazette Special Pathologist.

W. E. S. C., Balham High Road.—This specimen contains a little muco-pus, but tubercle bacilli are not detected.

A. E. L., Buckingham.—This is a malignant growth, having the structure of a squamous epithelioma. It is composed of epithelial ingrowths with cell-nests and keratinoid changes.

PATHOLOGIST.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the Gazette *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Nerves and the War.

CLINICAL LECTURE BY ARTHUR F. HERTZ, M.D.

Gentlemen,—Nervous disorders are not uncommon among soldiers invalided from the front. These cases are worthy of careful study, as they throw new light upon the etiology of various functional and organic conditions, and much suffering is prevented and the period of incapacity for service is greatly shortened if an accurate diagnosis is made and adequate treatment is adopted at an early stage.

I have seen examples of all varieties of functional disorder, but I shall only discuss neurasthenia, psychasthenia and hysteria, leaving insanity to Dr. Craig. *Neurasthenia*, or nerve exhaustion, has been exceedingly common, especially among men in the original expeditionary force, who suffered the hardships of the retreat from Mons and the fighting at Ypres, in addition to exposure to unfavourable climatic conditions during many weary months in the trenches. It would require a very exceptional nervous system to pass through nine months of war without exhaustion, even in the absence of shock due to actual wounds.

In all cases the primary factors have been physical fatigue and mental strain. For this reason officers have suffered more than men, as they have been exposed to equal fatigue, but have had more mental strain, especially when unexpected responsibilities have fallen upon young officers, whose seniors have been killed or wounded. In some cases there has also been a toxic factor. A subaltern in the flying corps, who was actively engaged almost daily from September, appeared to have passed unscathed through all the fatigue and excitement until January, when he had an attack of acute tonsillitis. He was taken to a hospital, where there was a shortage of food, and he was then conveyed in a half starved condition to England, the journey occupying over thirty hours. The fatigue and insufficient food were not new experiences, but the addition of the intoxication caused by the tonsillitis, which by itself would have only led to a few days of illness, was sufficient to cause a condition of severe nervous exhaustion, the recovery from which has, however, been remarkably rapid. I have seen several cases of neurasthenia following anti-typhoid inoculation, when the patient had to march a long distance immediately afterwards. Fortunately the authorities have now issued an order that all inoculated men should be off duty for forty-eight hours. Though insufficient food has aggravated the exhaustion in some cases, thanks to the excellent commissariat arrangements I have seen no instance in which intoxication from bad food has played an important part.

A very important group of cases is that in which an injury is the exciting cause. Every wound is likely to result in neurasthenia, if the soldier is already over-fatigued from mental and physical strain; the physical shock at the moment, combined with pain, loss of blood and septic poisoning are likely to depress the strongest nervous system. The most interesting cases of traumatic neurasthenia are those in which no actual wound is present, but concussion results from the bursting of a high explosive shell in the immediate neighbourhood. When, after a varying interval, the patient recovers consciousness, symptoms of traumatic neurasthenia are almost invariably present, their severity depending upon the degree of the concussion and the condition of the patient's nervous system before the injury. One of the worst cases of this sort I have seen was an officer, whose nervous system was already abnormal, as he had never completely recovered from the effects of concussion due to a fall on his head whilst hunting in February of last year.

The symptoms of neurasthenia are familiar to you all. A feeling of great fatigue is always present, the patient being unable to exert himself either physically or mentally. In severe cases he likes to lie like a log in perfect silence and a darkened room with his mind completely blank; it is only when improvement begins to occur that he desires cheerful surroundings, but even then exercise and thinking require an unpleasant effort. Insomnia is very common, and

many men wake up in the early hours of every morning to repel a nightmare attack by the Germans. I have seen well-marked tremor in several cases, and I have noticed it among officers who have been home on leave for a few days and who have regarded themselves as perfectly fit. Curiously enough the appetite is generally excellent, the digestion is good, and constipation is most unusual, the absence of digestive symptoms apparently being a peculiarity of war neurasthenia.

Complete physical and mental rest are essential in the treatment of neurasthenia. The patient must be kept in bed until he no longer feels tired. In very slight cases a week or fortnight may be enough, but two or three months may be required, especially in traumatic cases. No visitors should be allowed, except one or two relations or friends whom the patient particularly wishes to see, and frequent changes of nurses are most undesirable. The patient should be in a room by himself and not in a ward until considerable improvement has occurred. Quiet is essential, and bright sunshine should be avoided. The patient should not read at first, but he may be read to; all exciting literature should be avoided, and the patient's correspondence should be censored by some relative in whom he has confidence. He should not talk about his experiences in the war, but should try to forget the scenes he has passed through. Visits from relations of comrades who have fallen have a deplorable effect, and the constant repetition of harrowing experiences expected by the patient's relations and friends should not be allowed.

The etiology of *psychasthenia* is similar to that of neurasthenia, but mental strain always plays an important part; the same symptoms are present with the addition of some phobia or obsession. I have seen a few war cases, in which agarophobia, or dread of open spaces, was well marked. The most striking case of an obsession was in a captain, who, with one lieutenant, was the sole survivor among the officers of his battalion at the battle of Ypres. He received a D.S.O. for his gallant conduct on that occasion, but the enormous and unexpected responsibility, which devolved upon him when he was left in command, was too much for him in his physically exhausted condition. Though he had saved the remnant of his battalion through his own almost unaided efforts, he felt that he could never face any responsibility again and that the next occasion he was in danger he would have so little control over himself and his men that he would disgrace himself. This obsession took complete hold of him and he became more and more depressed in consequence. When, after many weeks spent in the trenches, he heard that there would be an attack on Neuve Chapelle the following day, he broke down completely, but with a supreme effort he got through the first day of the battle. Though he did very well, he was more miserable than ever in the evening and felt he could not face another day's fighting. He was invalided home and arrived in a condition of profound exhaustion and utter misery, as he thought he had disgraced himself for ever. His appetite remained good, and there was no insomnia. The treatment for such a case is the same as for neurasthenia, but complete rest alone would be insufficient to restore the patient's confidence in himself. Suggestion in the hypnotic state was clearly indicated, and was followed by such rapid improvement that the patient is now almost well.

Hysteria has occurred not infrequently among soldiers, though much less often than neurasthenia. In a large majority of cases it has been grafted upon a definitely organic basis, and I have only seen two cases of pure hysteria. A Belgian soldier was sitting on a roof observing the enemy, when the roof collapsed and he fell a short distance into the mud below, but without hurting himself in any way. It was over an hour before he could extricate himself, as his left leg was embedded in the mud. When at last he was able to crawl away, he found that he could not move his leg, which was fixed rigidly in an extended position. As no improvement occurred during the next few days, he was sent to England. When I saw him three months later, his condition was unaltered, and he was still unable to walk without assistance. The left leg was absolutely

rigid, but he did not walk as if he had an organic spastic paralysis, but dragged the leg behind him. There was no voluntary movement, and the knee and ankle could only be bent by using considerable force. The whole leg was completely anæsthetic to all forms of stimulation. The plantar reflex of both sides was flexor; the knee and ankle jerks were unobtainable on the left side owing to the impossibility of relaxing the muscles. There was no other evidence of disease in his nervous system. The absence of any organic sign combined with his extraordinary gait, which was quite different from that of any organic disease, made me quite certain that the paralysis, spasm and anæsthesia were hysterical. Additional proof of this was obtained from Babinski's second sign. When he lay down with his arms folded and legs widely separated and tried to sit up, the normal leg rose in the air and the paralysed leg remained fixed to the ground, whereas in an organic upper neurone paralysis the affected leg would have risen higher than the normal one. The paralysis and rigidity resulted from perpetuation by auto-suggestion of the immobility in an extended position caused by the leg being fixed in the mud. In all probability the anæsthesia was produced by suggestion by one or more of the numerous people who had examined him during the three months he was incapacitated, as my experience agrees with that of Babinski that hysterical anæsthesia is never the result of auto-suggestion, but is always produced by the observer. Having decided that the condition resulted from suggestion, it only remained to remove it by suggestion. I passed a strong faradic current through the affected leg and told the patient that this treatment was quite certain to restore his sensation and his power of movement. He improved at once, but was still only able to walk with difficulty. I therefore hypnotised him, and suggested that he should move his leg in a normal manner. Mr. Harper repeated the treatment on several occasions, and at the end of three weeks he was sufficiently well to be able to return to duty, though he still kept his left leg somewhat stiff when he walked. It was very easy to hypnotise him so deeply that one could produce hallucinations, which disappeared on waking. I believe this is a characteristic of his race.

I have seen several cases of hysterical paralysis following injury to peripheral nerves. It is very important to recognise this condition, as recovery can then be greatly accelerated. If a nerve is injured in such a way that it becomes functionless, the patient becomes so accustomed to the paralysis that when the nerve recovers sufficiently to convey voluntary impulses, no such impulses originate in the brain. Early in January an officer received a bullet wound in his arm, which resulted in complete paralysis and anæsthesia in the distribution of the median nerve. On January 20th Mr. Steward exposed the nerve and found that it was embedded in connective tissue, but it was not actually divided. The nerve was freed and the wound healed. I saw him on March 9th and found that the anæsthesia and paralysis were still complete, but all the muscles contracted briskly wtih faradism: this showed that there was no longer any nerve degeneration. With a little persuasion I managed to get him to move his fingers, and by repeating the faradism and persuasion a considerable amount of improvement occurred in the course of a few days. At the end of this time the paresis and partial anæsthesia, which were still present, were probably organic, the hysterical element having been cured by suggestion and persuasion. In all cases of injury to peripheral nerves, whether they have been completely divided or not, the muscles should be tested from time to time by faradism, and as soon as they respond the patient should be persuaded to make an effort to contract the muscles voluntarily, as otherwise the paralysis is likely to be maintained by auto-suggestion for several weeks or even months.

I have seen a number of cases, in which pain, caused by some organic condition such as an injury to a nerve, has continued with great severity after the removal of the cause. The patient's nervous system was profoundly depressed in every case, and it seems probable that the pain was due to auto-suggestion. In

such cases cheerful surroundings and plenty of people to talk to are needed rather than the quiet and isolation which are necessary for neurasthenia. An officer, from whom Sir Alfred Fripp had removed a bullet in the immediate neighbourhood of the sciatic nerve, still complained of excrutiating pain in the distribution of the nerve. We discussed the question of injecting the nerve with eucaine or saline solution so as to render it temporarily anæsthetic, but nothing of the kind was required, as he improved directly he was removed from a private room to a large and lively ward. In intractable cases suggestion would doubtless prove of value. An officer, who complained of constant severe pain in his back, where he had been struck by a bullet, which had passed through his coat without touching his skin, was rapidly cured by means of high frequency, which acted, I expect, as much by suggestion as by any direct analgesic influence.

I have already referred to the form of neurasthenia, which results from concussion of the brain. *Concussion* of the spinal cord may also lead to profound depression in its functions. A Belgian soldier was shot in the lower dorsal region of his back, but the bullet passed out a few inches away from the point of entry without injuring the spine. He complained of no pain in the back, but he could hardly move his legs, and complained of violent shooting pain passing from his hips to his toes. I expected that the paralysis would prove to be hysterical, as there was no evidence of spinal injury, but the knee and ankle jerks had disappeared on both sides, and this never occurs in hysteria. It seems probable that the blow on the back had led to such depression in the functions of the lower neurones that paralysis of a lower neurone type had resulted, and at the same time the sensory tracts were irritated. The paralysis slowly improved with electrical treatment, but the jerks were still absent and some pain was still sometimes felt when the patient left the hospital about three months after the injury.

So far as I know such a condition as concussion of peripheral nerves has not hitherto been recognised. I have, however, seen several cases of paralysis with anæsthesia, paræsthesia or hyperæsthesia in the distribution of peripheral nerves, which had not been actually injured, but which had been subjected to concussion as a result of the passage of a bullet in their immediate neighbourhood. In three cases, in which the sciatic nerve was involved, the ankle-jerk had disappeared. The electrical reactions of the paralysed muscles may be abnormal, but excitability to faradism is not often lost. This is an important point in diagnosis and prognosis, as it shows that the nerve is not actually divided or compressed, and that recovery is likely to be comparatively rapid.

Actual injuries to the nervous system do not come within the scope of a medical lecture. But I should like to warn you of the danger of being too conservative. In all injuries to the skull early operation is of the utmost importance, as otherwise the compression caused by hæmorrhage and inflammatory exudation is likely to cause irreparable damage. As soon as wounds involving peripheral nerves have been rendered aseptic, the nerves should be thoroughly exposed, if there is any doubt as to the extent of the injury, as it is often impossible to distinguish by electrical reactions or other means between compression and division of a nerve.

It should also be remembered that fixation of the limb in such a way that the paralysed muscles are completely relaxed, the wrist and fingers being hyperextended, for example, in musculo-spiral paralysis, is of far more importance than treatment by massage and electricity, valuable as these are. Every joint in the paralysed limb should be regularly moved from the earliest period, as it is obvious that a muscle which is just beginning to recover its power will remain functionally useless if the joints it moves are stiff. I have seen numerous cases, in which incapacity was greatly prolonged as a result of attention having been concentrated on the injury itself, while its results were neglected.

I have seen one case of multiple and symmetrical peripheral *neuritis* caused by exposure to cold and damp. The patient, an officer who had spent many hours in the trenches up

to his thighs in ice cold water and with his gloves constantly soaked, had been invalided home as a case of frost bite. He complained of weakness and painful tingling in his legs and hands. His knee, ankle and wrist jerks had all disappeared. I expect that peripheral neuritis is the cause of the symptoms in many cases of so-called frost bite, but this is the only case I have seen in which such definite evidence as loss of tendon reflexes was present. Very hot baths with faradism and massage gave great relief, and the patient has now, after two months, returned to duty, though the jerks are still very feeble. Few soldiers who had previously suffered from sciatica can have passed through the winter campaign without a recurrence, but now with the warmer weather cases of sciatica should become less frequent.

Experience has already shown how organic nervous diseases are aggravated by factors, such as fatigue and worry, which are often erroneously supposed to lead only to functional disorders, and I have little doubt that in years to come we shall see cases of paralysis agitans, disseminated sclerosis and other organic nervous diseases, in which the war will prove to have been the exciting cause. A colonel, who went out with the original expeditionary force, regarded himself as perfectly fit, though he had occasionally suffered from pains in the legs, which had been ascribed to rheumatism and neuritis. He had an exhausting time during the great retreat, and was invalided home directly afterwards. I found that he was suffering from typical and severe tabes, which had doubtless been present in a latent state before, but had become acute as a result of over-fatigue. I have not yet seen any cases of general paralysis of the insane, but the mental strain and physical fatigue of active service would be quite enough to give rise to the disease in an individual predisposed by syphilis, for what leads to neurasthenia in a normal man is likely to cause general paralysis in a syphilitic.

Books, etc., Received.—The Hospital, The London Hospital Gazette, The St. Mary's Hospital Gazette, The Nursing Times, The Polyclinic, The St. Thomas's Hospital Gazette, The M.S. Journal, The Prescriber.

The New Guy's Pharmacopœia.

FORMULÆ FOR CHILDREN.

The Doses are calculated for a Child twelve months old. For younger Infants the Doses must be proportionately reduced.

BALNEUM SINAPIS, Mustard Bath.

Take of

Mustard	30 to 900 G.	...	1 to 30 oz.
Water (37° C.: 98° F.)	5 to 150 Lit.	...	1 to 30 gal.

Pour a little of the warm water gradually upon the mustard in a basin, beating up the mixture into e smooth paste with a spoon. When well mixed, add tha mustard to the water. A child should usually be left in the bath for 10 minutes.

HAUSTUS CHLORAL INFANTUM, Chloral Draught fo Children.

Take of

Chloral Hydrate ...	12 Cg.	...	2 gr.
Potassium Bromide ...	12 Cg.	...	2 gr.
Syrup of Orange ...	1 Ml.	...	15 min.
Water to	4 Ml.	...	1 fl. dr.

Dissolve and mix.

Dose: 4 mils: 1 fluid drachm.

INJECTIO APOMORPHINÆ INFANTUM, Hypodermic Injection of Apomorphine for Children, contains 0·65 Mg. ($\frac{1}{100}$ gr.) of Apomorphine Hydrochloride in 5 Dl. (8 min.).

Dose: 1 to 5 decimils: 2 to 8 minims.

INJECTIO ATROPINÆ INFANTUM, Hypodermic Injection of Atropine for Children, contains 0·13 Mg. ($\frac{1}{500}$ gr.) of Atropine Sulphate in 5 Dl. (8 min.).

Dose: 1 to 5 decimils: 2 to 8 minims.

INJECTIO MORPHINÆ INFANTUM, Hypodermic Injection of Morphine for Children, contains 1 Mg. ($\frac{1}{64}$ gr.) of Morphine Tartrate in 5 Dl. (8 min.).

Dose: 1 to 5 decimils: 2 to 8 minims.

INJECTIO STRYCHNINÆ INFANTUM, Hypodermic Injection of Strychnine for Children, contains 0·3 Mg. ($\frac{1}{200}$ gr.) of Strychnine Hydrochloride in 5 Dl. (8 min.).

Dose: 1 to 5 decimils: 2 to 8 minims.

MISTURA ACIDI HYDROCHLORICI. Hydrochloric Acid Mixture.

Take of

Diluted Hydrochloric Acid ...	12 Cl.	...	2 min.
Glycerin	7 Dl.	...	12 min.
Water to	4 Ml.	...	1 fl. dr.

Mix.

Dose: 4 mils: 1 fluid drachm.

MISTURA ALOES ET SENNÆ. Aloes and Senna Mixture.

Take of

Tincture of Aloes	18 Cl.	3 min.
Tincture of Belladonna	12 Cl.	2 min.
Syrup of Senna	1 Ml.	15 min.
Sodium Sulphate	6 Dg.	10 gr.
Peppermint Water to	4 Ml.	1 fl. dr.

Dissolve and mix.

Dose: 4 mils: 1 fluid drachm.

MISTURA AMMONIÆ ET IPECACUANHÆ. Ammonia and Ipecacuanha Mixture.

Take of

Ammonium Carbonate	6 Cg.	1 gr.
Ipecacuanha Wine	12 Cl.	2 min.
Gluside	2 Mg.	$\frac{1}{32}$ gr.
Cinnamon Water to	4 Ml.	1 fl. dr.

Dissolve and mix,

Dose: 4 mils: 1 fluid drachm.

MISTURA BELLADONNÆ COMPOSITA. Compound Belladonna Mixture.

Take of

Tincture of Belladonna	18 Cl.	3 min.
Sodium Bicarbonate	12 Cg.	2 gr.
Syrup	1 Ml.	15 min.
Water to	4 Ml.	1 fl. dr.

Dissolve and mix.

Dose: 4 mils: 1 fluid drachm.

MISTURA BISMUTHI ASTRINGENS. Astringent Bismuth Mixture.

Take of

Bismuth Oxycarbonate	12 Cg.	2 gr.
Aromatic Powder of Chalk with Opium	6 Cg.	1 gr.
Compound Catechu Powder	20 Cg.	3 gr.
Water to	4 Ml.	1 fl. dr.

Mix.

Dose: 4 mils: 1 fluid drachm.

MISTURA BISMUTHI CUM HYDRARGYRO. Bismuth and Mercury Mixture.

Take of

Solution of Mercuric Chloride	18 Cl.	3 min.
Tincture of Belladonna	18 Cl.	3 min.
Compound Tincture of Camphor	24 Cl.	4 min.
Bismuth Mixture to	4 Ml.	1 fl. dr.

Mix.

Dose: 4 mils: 1 fluid drachm.

MISTURA CARMINATIVA. Carminative Mixture.

Take of

Compound Tincture of Cardamoms	3 Dl.	5 min.
Aromatic Spirit of Ammonia	12 Cl.	2 min.
Syrup	6 Dl.	10 min.
Anise Water to	4 Ml.	1 fl. dr.

Mix.

Dose: 4 mils: 1 fluid drachm.

MISTURA CREOSOTI ET MORPHINÆ. Creosote and Morphine Mixture.

Take of

Creosote	3 Cl.	$\frac{1}{2}$ min.
Castor Oil	3 Dl.	5 min.
Solution of Morphine Hydrochloride	6 Cl.	1 min.
Gum Acacia, in powder	12 Cg.	2 gr.
Water to	4 Ml.	1 fl. dr.

Emulsify.

Dose: 4 mils: 1 fluid drachm.

MISTURA IPECACUANHÆ COMPOSITA. Compound Ipecacuanha Mixture.

Take of

Potassium Citrate	12 Cg.	2 gr.
Ipecacuanha Wine	12 Cl.	2 min.
Syrup of Balsam of Tolu	3 Dl.	5 min.
Tincture of Squill	6 Cl.	1 min.
Compound Tincture of Camphor	24 Cl.	4 min.
Water to	4 Ml.	1 fl. dr.

Dissolve and mix.

Dose: 4 mils: 1 fluid drachm.

MISTURA RHEI ET MAGNESIÆ. Rhubarb and Magnesia Mixture.

Take of

Compound Tincture of Rhubarb	3 Dl.	5 min.
Solution of Magnesium Bicarbonate	1 Ml.	15 min.
Syrup of Ginger	1 Ml.	15 min.
Caraway Water to	4 Ml.	1 fl. dr.

Dissolve and mix.

Dose: 4 mils.: 1 fluid drachm.

PULVIS BISMUTHI ASTRINGENS. Astringent Bismuth Powder.

Take of

Bismuth Oxycarbonate	12 Cg.	2 gr.
Tannic Acid	6 Cg.	1 gr.
Aromatic Powder of Chalk to	30 Cg.	5 gr.

Mix.

Dose: 30 centigrams: 5 grains.

PULVIS CALOMELANOS CUM OPIO. Calomel and Opium Powder.

Take of

Mercurous Chloride	10 Mg.	$\frac{1}{6}$ gr.
Compound Powder of Ipecacuanha	10 Mg.	$\frac{1}{6}$ gr.
Milk Sugar to	6 Cg.	1 gr.

Mix.

Dose: 6 centigrams: 1 grain.

PULVIS HYDRARGYRI CUM CRETA ET SODÆ, Grey Powder and Soda, is kept in Tablets containing 30 Mg., 6 Cg., 12 Cg., 20 Cg., 25 Cg., 3 Dg., 4 Dg. ($\frac{1}{2}$, 1, 2, 3, 4, 5, and 6 gr.).

Take of

Mercury with Chalk	6 Cg.	1 gr.
Sodium Bicarbonate	20 Cg.	3 gr.

Mix.

Dose: 12 to 25 centigrams: 2 to 4 grains.

PULVIS RHEI ET CALOMELANOS CUM SODA, Rhubarb, Calomel, and Soda Powder.

Take of

Rhubarb, in powder ...	... 6 Cg. ...	1 gr.
Mercurous Chloride ...	... 6 Mg. ...	$\frac{1}{10}$ gr.
Sodium Bicarbonate ...	... 6 Cg. ...	1 gr.

Mix.

Dose: 12 centigrams: 2 grains.

PULVIS RHEI ET SODÆ, Rhubarb and Soda Powder, is kept in Tablets containing 20 Cg., 25 Cg., 3 Dg., 4 Dg. (3, 4, 5, and 6 gr.).

Take of

Rhubarb, in powder ...	... 12 Cg. ...	2 gr.
Gluside	... 2 Mg. ...	$\frac{1}{32}$ gr.
Ginger, in powder ...	... 30 Mg. ...	$\frac{1}{2}$ gr.
Sodium Bicarbonate to	... 30 Cg. ...	5 gr.

Mix.

Dose: 30 centigrams: 5 grains.

PULVIS SANTONINI COMPOSITUS, Compound Santonin Powder.

Take of

Mercurous Chloride ...	... 6 Cg. ...	1 gr.
Scammony Resin, in powder	12 Cg. ...	2 gr.
Santonin, in powder ...	... 12 Cg. ...	2 gr.

Mix.

Dose: 20 to 30 centigrams: 3 to 5 grains.

Obituary.

EDWARD FRANCIS HERMAN HARDENBERG,

M.B. Lond., M.R.C.S., L.R.C.P.

Many Guy's men will be grieved to hear of the death, at the early age of 44, of Edward F. H. Hardenberg. His fatal illness commenced in November, 1913, and from that time to his death, 22nd March of this year, he had to pass through a most distressing call upon his courage and patience. Fully aware of his condition he faced his fate with exemplary fortitude, and to the last his friends and attendants were stirred to admiration at the brave and cheerful spirit manifested. His confrères in the West Herts Division have lost a loyal and most highly esteemed colleague: he was a staunch member of our association.

After a distinguished career at Guy's he joined W. F. Haycroft-Berry in partnership at Watford in 1897, and from the first settled down in earnest to the exacting demands of a large and important practice. Careful, methodical, and most painstaking he acquired, as the years went past, the full confidence of his patients with, at the same time, an increasing public regard. His Dutch extraction contributed to the eminently critical methods of practice he adopted. The excellencies of a "Guy's man" were manifested daily in his detailed work, and it was a pleasing feature during his painful illness to see how spontaneously his former teachers, Dr. G. Newton-Pitt in particular, came to his assistance.

Probably the highest tribute to his memory is the work he did as Medical Officer for the children of the London Orphan Asylum. He gave unstintingly of his best for their welfare, a service warmly appreciated by the Governors of that Institution. The children were devoted to him.

Outside the routine of practice Dr. Hardenberg maintained a keen interest in literature and was well versed in classical French and German authors. A life of hard work in general practice, over at 44, is in reality a tragedy. Short though his career was, Dr. Hardenberg left behind him a memory which his colleagues will cherish and a reputation of honour to his profession.

The interment took place at the Watford Cemetery, March 26th, and the large attendance of colleagues, of representatives of public bodies, and of the general public testified to the respect in which Dr. Hardenberg was held.

Dr. Hardenberg was educated at Forest School, and entered Guy's in October, 1899 (having taken honours in the London Matriculation) as a Prelimary Science Student. He was Surgical Ward Clerk to Mr. Durham, Medical Ward Clerk to Dr. Pye-Smith, Assistant Surgeons' Dresser to Mr. Lane, and Surgeons' Dresser to Mr. Lucas. While Clinical he was under Dr. Pitt and Dr. Washbourn, and then formed a lifelong friendship with Dr. Pitt.

He qualified in April, 1894, and was appointed A.H.S. in July. From October, 1894, to March, 1895, he was H.S. to Mr. Howse and Mr. Jacobson. He was a contemporary of Mr. Steward and fellow H.S.

He was one of the first members of the "Disguysed Minstrels," and, being a very good pianist, acted as accompanist at the various smokers; he was also known amongst his friends as "Dutchy."

After leaving Guy's he took the M.B. London with honours in Forensic Medicine, and then did a few locums, including one at Watford. After a year's assistantship with Dr. Butcher at Ware, he went into partnership with Dr. Berry at Watford in 1897.

He worked extremely hard, and in February, 1912, had to take two months holiday on account of high arterial tension. The next winter he commenced to work as hard as ever and in November had a cerebral hæmorrhage. In May, 1914, he had an attack of uræmia, but thanks to the great care of Dr. Pitt and Dr. Hall he pulled round. At the beginning of this year he relapsed, and gradually getting worse, died on March 22nd. He mar-

ried Annie Margaret Graham Weall, of Watford, in 1903, and leaves a widow and three children (two boys and one girl). Many Guy's men came to see him during his last illness, including Mr. Symonds, Dr. Hale White, Mr. Steward, Dr. Beddard, and Mr. Ormond.

He was for some time President and Secretary of the Guy's '89 Club.

Nursing News.

Matron's Office,

March, 1915.

The C.H.R. Nursing Sisters all report that the censorship has become very strict, and they may not even report if they are very busy, several correspondents only sending post cards for that reason. This is naturally disappointing to all friends at home, as it is of great interest to know of the doings of all Guy's workers abroad.

From Versailles we hear that Sister Brown is Night Superintendent and that she and the Misses Hickman, Hepburne, and Druce are Reserve Sisters.

Warm spring sunshine is reported and also an extraordinarily heavy fall of snow last week.

Misses Tyler-Cove, Foxon, and Tyndale arrived safely at Boulogne, and received orders to join No. 12 Stationary Hospital.

Miss Mallandaine, who has been working at the Diocesan Mission Hospital, Kwa Magwasa, Zululand, since 1902, returned to England in March to take up war nursing and has gone, under the auspices of the War Office, to one of the General Hospitals in France.

Miss I. Keeble says that the club for the Army Nurses in Boulogne is a great boon. Papers are provided and tea and baths can be obtained—two very great wants in the nursing life abroad.

Croix Rouge de Belgique,
Hôpital ——,
La Paune, Belgium.

From Miss Mackenzie Lawson to Matron.

"I came to this hospital about January 3rd, and I believe we are the nearest to the fighting line. We have not been shelled yet; they are trying hard to get the range of this place, but so far have not succeeded. Furnes, four miles away, is bombarded nearly every day. Two of us walked there the other day, and we received a warm reception. Just before we entered the town a shell tore through, killing three people, so we only stayed to take a hasty look round and a snap-shot for my Kodak and then fled, just in time to escape another shell. We got the poor victims in hospital that evening. I shall not go to Furnes again.

"We get many German aeroplanes over La Paune when the weather is fine; they have dropped lots of bombs, but so far we have not been hit. Several of us who were out walking had narrow escapes, the bombs bursting quite near, but fortunately the sandy dunes prevented the pieces from flying far, otherwise there would have been no escape.

"The first day they came I got a piece of the bomb, but when the bomb throwing is continuous one loses all desire for such souvenirs.

"To-day is fine, and as I write there is an aeroplane overhead; all the guns are firing at it, but they never seem to hit. One becomes quite a fatalist and does not worry—it is the only way. On those days the theatre is kept busy.

"This hospital is run by Belgian doctors. We get a good deal of gas gangrene and the mortality is very high. One longs for our own men and lots of cyanide gauze, biniodide, and peroxide. Awful things are done without any anæsthetic. . . . All we can do is to try to give the poor things extra kindness and attention afterwards, and they are very grateful.

"King Albert came to see the wounded a short time ago. I do think he is a splendid man, and I was very pleased when I was presented to him. He talked for a few minutes, and seemed glad when I told him the men bore their pain so well. He was very simple and charming, and you will be glad to hear that he told Matron that the English nurses were the best in the world.

"The Queen also visits here often, and brings cigarettes and chocolates for the men. I am the only Guy in La Paune, I believe, but there are quite a number in Boulogne. Thank you so much for the post card with the view of the Nurses' Home; it looks so peaceful and nice. One does so appreciate everything English now."

Miss Phillips, writing to friends "on the District," mentions the terrible rush and stress after Neuve Chapelle: 2,000 cases came to one hospital in a week and the equipment was for only 500 beds. "It is all too frightful; oh, the poor men. I never want to see a secondary hæmorrhage again or another amputation. One longs for peace and can only plod on and work as cheerily as possible."

Miss Windley writes from Institution Jeanne d'Arc, Calais :—

"I have been here since January 4th nursing Belgians. Most of the Sisters are English, and there are a few half-trained Belgian helpers. My greatest trial is the daily trudge, for we sleep at a house a mile and a quarter away, and it seems a long way off before 7.30 a.m. breakfast and after 8 p.m., and it is generally raining.

"The raid this week was most terrifying. I watched it all after the first explosion. The searchlights were working hard, and the big and quick-firing guns going all the time. We could see the shrapnel bursting in the sky as well as the bombs exploding. Afterwards some of the wounded were brought in badly hurt.

"This building was a large school and now holds 130 beds. The ground floor rooms are turned into small wards of about 8 to 10 beds each.

"I have charge of the second floor, including an officer's ward of 12 beds and one for men with six beds, and a private appendix case in a small room down the corridor, so there is plenty of running about.

"On the top floor is a big ward of 35 beds where most of the minor wounds go. I had that for my first six weeks and liked it very much, for I persuaded the doctor to let me do all the dressings. They were very suspicious at first, but now they have come to the conclusion that some of the English sometimes know something.

"The other large hospital here is staffed with English, and Sisters Randles, Spurway, and Twilliam were there, but have been recalled to Boulogne. The new typhoid hospital in huts of 300 beds will be ready next week.

"I cannot think why Calais has been chosen, for the sanitary arrangements are dreadfully primitive. I shall appreciate England on my return. It is difficult to be clean here. We are only allowed two pints of hot water a day now, and baths are nearly impossible."

Miss B. Martin writes from Havre:—

"Sister F. Davies and I were moved from the "Asturias" just two months ago, and have been at Havre since. We like it better than the ship, but we are not together: she is at the Casino and I am at a Clearing Hospital. We have very good work, but one often longs to see the patients through and not lose sight of them so quickly.

"I fear the home hospitals must be very overtaxed, for during this past week such numbers have gone through—1,200 in one day for the ships—after Neuve Chapelle.

"I have not met any Guy's here, but frequently hear of them from other Sisters, and always to their great credit, of which I feel very proud.

"The hospital is well equipped. Miss Richards is the Matron; she was at Millbank before the war, and is most proficient. She is in charge of three hospitals here."

Anglo-Ethiopian Hospital,
Frévent, Pas de Calais,
March 21st, 1915.

"I hear letters are welcome from the Front, and as we are within sound of the guns at Arras I feel we are nearer than most unofficial hospitals. This hospital (65 beds) is run by Mrs. Doughty Wyllie, the wife of the British Ambassador in Abyssinia, hence its curious name. We have been going since Christmas, several catches of 'grands blessés' having been sent to us. The nurses are English, and we have some French Red Cross orderlies. They are all priests, and at first it seemed strange to have a 'reverend Father' working as a junior pro., but one gets used to it, and a junior pro. is, on the whole, a much more satisfactory worker. The hospital is part of a hospice kept by nuns, and the wards are really almost like home wards.

"Water, however, has to be carried up from a pump in the yard, and the sanitary arrangements are shocking, but so far we have had nothing worse than sore throats. We have entirely French patients, and I like them very much, though they do not love fresh air or too much soap and water. However, they soon get used to the ways of the "Anglaises," and resign themselves heroically to having their shirts taken off once a day and to having a window open now and then.

"We have only had one case of tetanus, several of gas-gangrene, and just lately a case of cerebro-spinal meningitis from one of the regiments quartered here. Our X-ray apparatus comes round on a motor-car whose engine works the photography apparatus, and Madame Curie (of radium fame) superintends the radiography for this district. The wounds sent in are all shell or bullet; we have seen no bayonet wounds at all.

K. J. CADELL.

Appointments.

Medical School Appointments.

April–June, 1915.

Clinical Assistants in Surgical Wards.—Messrs. V. R. Hirsch (Mr. Dunn); A. D. Marston (Mr. Steward).

Dressers and Clerks in Special Departments:—

Throat and Ear, Genito-Urinary, and Children.—Messrs. I. R. R. Brogden, E. S. Bowes.

Throat and Ear, Skin, and Orthopædic.—Messrs. W. H. A. Pratt, E. M. Litchfield.

Eye and Nervous System.—Messrs. J. E. Clark (Mr. Eason), C. W. W. Baxter (Mr. Ormond).

Obstetric Dressers and Externs.—Messrs. D. H. A. Galbraith, H. M. Gray, W. D. Newland (Mr. Bellingham Smith); P. G. McEvedy, J. G. Jones, A. Traill, J. Kyle (Mr. Chapple).

Surgeons' Dressers.—Messrs. K. M. Woodruff, E. N. Glover, M. B. M. Tweed (Sir W. A. Lane); W. B. Buer, H. S. Wacher, D. V. Halstead (Mr. Dunn); M. Pearson, W. Burridge, R. L. Portway (Sir A. Fripp); H. J. Bensted, G. E. L. Simons, W. J. Vance (Mr. Steward).

Medical Ward Clerks and Post-mortem Clerks.—Messrs. T. E. Micklem, I. Tewfik, R. R. Traill, W. G. S. Neely (Dr. Hale White); L. S. Gathergood, F. N. Sidebotham, P. D. Chapman, A. F. G. Guinness (Dr. Shaw); E. S. Phillips, E. A. Leviseur, H. I. Sterne Howitt, A. M. Ahmad (Dr. Fawcett); D. M. P. Whitcombe, G. E. Kidman, M. C. Joynt, B. E. Jerwood (Dr. Beddard).

Medical Ward Clerks.—Messrs. L. A. B. Moore, O. St. L. Campion, J. C. C. Howe, J. O. R. Montocchio, V. Ramirez, S. W. F. Underhill.

Assistant Surgeons' Dressers.—Messrs. C. L. Odam, R. S. Millar, J. E. de Robillard, (Mr. Fagge); G. W. Heckels, A. W. A. Davies, S. Vidot (Mr. Rowlands); J. T. T. Forbes, H. St. H. Vertue, H. E. Bamber (Mr. Turner); T. L. Heath, J. M. H. Campbell, R. H. C. Pryn (Mr. Hughes).

Surgical Ward Clerks.—Messrs. G. W. Pratt, E. F. Deacon, E. C. Hinde.

Naval.

G. W. E. Holloway, from H.M.S. *Impregnable* to H.M.S. *Ganges II.*

L. S. Fry to the *Victory*, additional for Royal Naval Division.

Royal Army Medical Corps.

To be temporary Lieutenants:—H. H. Elliot, A. F. Rook, A. S. Seabrooke, H. H. Davis, C. R. Nicholson.

Capt. T. F. Brown, R.A.M.C., 1st Australian General Hospital, Australian Expeditionary Force, Egypt.

1st Eastern General Hospital.—P. N. Blake Odgers to be Captain, whose services will be available on mobilisation.

To the Red Cross (Weir) Hospital, George Packham, elected by the House Committee a Member of the Staff as Honorary Dental Surgeon.

Civil.

J. G. Porter Phillips, M.D., B.S., M.R.C.P., has been appointed Lecturer in Mental Pathology to the London (Royal Free Hospital) School of Medicine for Women (dated from November, 1914).

The Preston Education Committee have appointed Mr. H. P. Taylor, L.D.S., to be their School Dentist at a salary of £300 per annum.

List of Subscribers to Fund for X-Ray Apparatus for Private Hospital in Ghent.

It is with great satisfaction that Nurse de Laveleye and Nurse Maud Fletcher announce to their many supporters that their fund now amounts to over £200, and they wish to thank most sincerely all those who have been good enough to help them to attain their object. £200 was the amount first appealed for to enable them to purchase an X-ray apparatus, and they are now anxious to add to the sum they have already in hand to be able, if possible to provide for the upkeep during the war. Any further subscriptions will be gratefully received, and should be addressed to Guy's Hospital.

	£	s.	d.
Address at Ealing, per M. E. de Laveleye	22	2	6
Address at Norwood, per M. E. de Laveleye	18	0	0
R. J. T., London	10	10	0
Proceeds of Entertainment given by the Morningside pupils of Mrs. George Lowe, Edinburgh	10	0	6
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Baron and Baroness de Laveleye, Brussels...	2	2	0
Principal Whyte, D.D., Edinburgh... ...	2	2	0
H. Selby, Esq., London	2	2	0
Alfred Shepherd, Esq., W.S., Edinburgh	2	2	0
Robert Brown, Esq., Edinburgh	2	2	0
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David C. Robertson, Esq., Edinburgh ...	2	2	0

	£	s.	d.
J. Watherston, Esq., Edinburgh	2	2	0
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The Pupils of George Watson's Ladies' College, Edinburgh	2	2	0
Miss C. A. Atkinson, Harrogate	2	0	0
Collection, Chapel, Guy's Hospital, Christmas Day, per the Rev. G. T. Charlesworth ...	1	17	0
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"Oxford Street"	1	2	6
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Dr. C. H. Cameron, Guy's	1	1	0
Mr. and Mrs. Bune, Beckenham	1	1	0
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Lieut. D. G. Young, 10th Scottish Rifles ...	1	1	0
Miss Pickworth, Brighton	1	1	0
Wm. Montgomerie-Bell, Esq., Edinburgh...	1	1	0
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J. A. S. Carment, Esq., W.S., Edinburgh...	1	0	0
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Sir John M. Clark, Bt., Edinburgh ...	1	0	0
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"Bob"	1	0	0
The Misses Hope, Edinburgh	1	0	0
John R. Finlay, Esq., D.L., Edinburgh ...	1	0	0
Miss F. A. Howden, Edinburgh	1	0	0
Friends, Edinburgh	1	0	0
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Miss Mary Robertson, Edinburgh	1	0	0
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A. R. Dryburgh, Esq., Edinburgh	1	0	0
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Adam Tait, Esq., Edinburgh	1	0	0
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H. Maxwell, Esq., W.S., Edinburgh ...	0	10	6
S. H. Motion, Esq., Amersham	0	10	6
Mme. Loria-Leonino, Milan	0	10	0
"Ash Grove"	0	10	0
Miss M. Cochrane, York	0	10	0
Miss Stoddard, Blackpool	0	10	0
"Pearcie," Mrs. Gilbert	0	10	0
Mrs. J. E. Hayes, Winchester	0	10	0
H. J. Bradbrook, Esq., Borough	0	10	0
John Gibb, Esq., Edinburgh...	0	10	0
A. Cargill, Esq., Edinburgh	0	10	0
Miss W. E. Hunt, London	0	10	0
Lady John Taylour	0	5	0
Miss M. Turner, Bath	0	5	0
Mrs. Coward, Westminster	0	5	0
Nurse Allen, Guy's Institution	0	5	0
Miss Boog, Edinburgh	0	5	0
Miss M. L. Ewing, Edinburgh	0	5	0
Miss Ritchie, Edinburgh	0	5	0
Nurse Lyons, France	0	5	0
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Mrs. F. Barham, Epsom	0	5	0
Nurse C. M. Cromar, Rawal Pindi, India...	0	5	0
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Dorien Lane	0	2	6
Nurse A. Keast...	0	2	6
"Nurse Morrison"	0	2	6
Miss F. Marshall	0	2	6
"Two Nurses," South Devon	0	2	6
"Del"	0	2	0
"Eliza"	0	2	0
Miss A. A. Fairbairn, Brixton	0	2	0
"Anonymous," Edinburgh	0	2	0
Miss L. Millar...	0	1	6
Miss B. Huxtable	0	1	0
"Shrimp"	0	1	0
Miss Brown, Guy's	0	1	0
"Anonymous"	0	1	0
"Anonymous"	0	0	6
	254	16	3
Less Expenses paid out to date ...	2	18	3
	£251	18	0

Reviews, etc.

Notes on Dental Anatomy and Dental Histology (Human and Comparative). By T. W. Widdowson, L.D.S., R.C.S. Eng., etc. 3rd edition. (John Bale, Son and Danielsson, Ltd.) Price 7/6 net.

This is a companion book to the author's "Notes on Dental Surgery and Pathology." It is primarily intended for the use of students, and as such is interleaved with blank pages for notes and drawings. The printing

and illustrations are very good, especially those illustrations of the diagrammatic variety. The publication of a third edition has been rendered necessary by recent research in this science, *e.g.*, Howard Mummery's Nerve Endings in the Dentine, and these are all incorporated in this edition, so that the student may rest assured that in studying from these notes he is in full possession of the most recent knowledge. A little more than half of the book is devoted to Human Dental Anatomy, and the remainder to Comparative Dental Anatomy,—a result of the Examination Syllabus as at present constituted.

A few more illustrations to the comparative portion would perhaps have been advisable, but this can easily be remedied by the student himself. The book can be heartily commended to all students as an excellent basis for their study in this direction.

Medical Diagnosis. By Arthur Latham, M.A., M.D., F.R.C.P., and James Torrens, M.B., B.S., M.R.C.P. (Messrs. Churchill.) Price 15s.

Several good books on medical diagnosis have appeared during recent years both in England and abroad, but most, we think, are too elaborate and bulky for the average student or practitioner. This charge cannot, however, be laid against the one under consideration.

It is divided into six parts, the first of which treats of the specific infections, tropical diseases, and the commoner animal parasites; the second of diseases of the blood and ductless glands, disorders of metabolism, and the intoxications; then follow the various "system" diseases; and finally, in the last part, certain affections of the skin are briefly considered.

For the book, as a whole, we have formed the very highest opinion. Very little of importance would seem to have been omitted, yet it is in no sense of the word a "cram book." One of its most striking features is its extraordinary lucidity.

The section on tuberculosis is particularly good; that on syphilis might, perhaps, have been fuller. It contains, however, a clear account of Wassermann's reaction and of the demonstration of the spirochæte by means of the dark ground illumination. Burri's Chinese ink method might with advantage have also been mentioned. Practically all the more usual laboratory methods of diagnosis, however, are very well and clearly described, and even Cammidge's test and the diastase reaction for pancreatic efficiency are included. The section on the examination of the urine is also very good.

The introductory part of the diagnosis of diseases of the nervous system is clearly written and contains some excellent diagrams. Nervous diseases are notoriously the bête noir of most medical students, and this section will doubtless prove very helpful. The last part, dealing with diseases of the skin, might, we consider, have been omitted without detracting in any way from the value of the book. It is necessarily too brief to be of material aid.

On the whole, however, we most strongly recommend the work. It should prove invaluable to the junior student while doing his clinical work in the wards, to the senior man revising his knowledge before his final examination, and to the practitioner as a trustworthy book of reference. We may add that Messrs. Churchill merit congratulation for the excellent way in which the book has been produced.

Births.

DRYLAND.—On February 23rd, at Pitfour, Kington, Herefordshire, to Mr. and Mrs. G. Winter Dryland, a daughter.

KIDD.—On March 16th, at 54, Leeds Road, Harrogate, the wife of W. Shirley Kidd, M.B., B.S., of a daughter.

SWAN.—On March 26th, at Wimpole Street, the wife of R. H. Jocelyn Swan, M.S. Lond., F.R.C.S. Eng., of a son.

HELYAR.—On 3rd April, at 38, Wellington Square. Hastings, Sussex, the wife of Philip R. Helyar, L.D.S. Eng., a son.

Marriages.

JOHNSON—LESLIE.—On March 20th, at Richmond, Arthur Percy Livett Johnson, L.D.S. Eng., only son of the late Rev. A. N. Johnson, M.A., to Joan, youngest daughter of Mr. and Mrs. William Leslie, of Mauchline, Ayrshire.

PARKER—MURRAY.—On March 24th, Frederick Henry Parker, F.R.C.S., to May Murray, daughter of Dr. C. F. K. Murray, F.R.C.S., Kenilworth, South Africa.

PICKERING—RAINE.—On March 25th, 1915, at St. John's Wesleyan Church, Sunderland, Dennison Veitch, younger son of the Rev. T. R. Pickering, Gomersal, Yorkshire, to Lilian, youngest daughter of John Raine, Esq., J.P., 4, Clifton Villas, Sunderland.

POOLE—MARCHBANK.—On Wednesday, March 17th, at the Westgate Road Baptist Church, Newcastle-on-Tyne, by the Rev. J. T. Whitman, assisted by the Rev. S. V. Marchbank (brother of bride) Stuart Kingsley Poole, of Thanet House, Creswell, only son M. J. Poole, J.P., and Mrs. Poole, of Ramsgate, to Elizabeth Viccars, fifth daughter of the late J. Marchbank and Mrs. Marchbank, of 31, Grove Street, Newcastle-on-Tyne.

PACKHAM—KEEP.—On the 27th March, at St. George's Church, Hanover Square, by the Rev. Theodore Wood, George Packham, L.D.S. Eng., to Winifred Norah, youngest daughter of Charles Claude Keep.

Deaths.

BODKIN.—On the 18th March, at Trevelyan House, Tiptree, Essex, Basil Frederick, youngest son of Mr. and Mrs. A. Malcolm Bodkin, aged 7 months.

KIDD.—On March 27th, at 54, Leeds Road, Harrogate, Philippa Olive, wife of W. Shirley Kidd, M.B., B.S., aged 26.

W. E. T.

GUY'S HOSPITAL GAZETTE.

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Passim.

WE have received several complaints concerning the difficulty men experience in attending the post-mortem room regularly. The importance of correlating pathology with clinical observation cannot be overestimated, for only in this way is it possible to get a mental picture at the bedside of the pathological condition which gives rise to a certain physical sign. The properly-trained student of morbid anatomy has a visual mental picture of the lung he examines with the stethoscope. This ideal is only obtainable by a regular daily attendance in the post-mortem room. A correspondent writes :—

"Personally I should like to go to P.M.'s every day, but with one's physician going round most days at 2 p.m., it is difficult to be in two places at one and the same time. Do you think that you could suggest in the GAZETTE or elsewhere that when possible P.M.'s should be held daily at 1 o'clock? Between 12 and 2 the average ward clerk has nothing to do, and would only be too keen to attend P.M.'s."

This seems to us an excellent suggestion, but we do not know if it is possible for the Visiting Staff to attend the Hospital so early—that is a matter on which we cannot offer an opinion.

Certain physicians here used to go down to the post-mortem room at 4 o'clock to demonstrate the morbid appearances of cases which had been treated in their wards. We do not know if this practice is still carried out, but everyone appreciated these informal demonstrations, which were most valuable.

In former years one could study morbid anatomy at the pathological meetings of the Physical Society, but unfortunately this society has held no meetings this year, owing to the war.

THE Annual General Meeting of the Students' Club was held on March 30th. Besides the officers, five members only were present. Important business involving a proposal to spend £120, and to withdraw the club's subscription to Mudie's Library were considered. This lack of enthusiasm is deplorable. It is desirable that members should take a personal part in the management of the club and not make ineffective complaints amongst themselves in private.

THE engagement is announced of Mr. Samuel T. Weston, of Lahore, India, and Miss Katherine B. Webb, late Assistant Matron, Guy's Hospital, and at present the Superintendent Sister, Mayo and Albert Victor Hospitals, Lahore. Miss Webb has many friends among the nurses and men of Guy's, past and present; we offer her our hearty congratulations and good wishes.

THERE is a vacancy for a junior officer in the 2/3 London Field Ambulance. Candidates must be willing to undertake foreign service with the

unit. This ambulance has already sent out 200 men and 3 officers to the front; instructions have been given to supply no more drafts. An officer is also required for the 2/3 London (City of London) Field Ambulance, T.F. For further particulars apply to Lt.-Col. G. L. L. Lawson, O.C. 2/3 London Field Ambulance, Heathfield.

Mr. Dennis Brown and Mr. Clive Carey, ex-Conductors of the Guy's Hospital Musical Society, are now on active service for their country. Mr. Dennis Brown is in the navy and has gone to the Dardanelles.

Scene.—John Ward.

Two cases have just been brought back from the Examination Hall, two boy patients overheard discussing them.

"Where 'ave they been?"

"To be examined, I've been three times. The last time they gave me 6 bob."

"Wish I could go!"

"Oh, you ain't no 'case.' You ain't got a big stomick like me."

"Yus, I 'ave."

"But not with marks on it like mine. It was all pencil marks last week, now it's all over ink marks, you ain't interesting enough."

"Yus, I am."

"Well, what did Dr. Barber say when he came round and examined you?"

"Why, 'e ses, 'I dunno what's the matter with the kid.'"

Queen Alexandra Relief Fund for War Nurses.—At the committee meeting recently held, a sub-committee was appointed consisting of all the matrons on the general committee to receive and deal with applications for assistance. Forms for the purpose can be obtained from the Hon. Sec. C. Douglas Pennant, Esq., 15, Buckingham Street, Strand, London, W.C.

Dr. Fraser, Honorary Secretary of the Junior Guyite Club, wishes to inform members that, owing to the war, the Annual Dinner will not be held as usual in May this year.

Obituary.

WILLIAM ARTHUR BRAILEY,
M.A., M.D. Cantab.

Consulting Ophthalmic Surgeon, Guy's Hospital.

We regret to announce the death of Dr. W. A. Brailey which took place in London on April 8th after a few days' illness. The only son of the Rev. William Brailey, he was born at Uttoxeter in 1845. Educated at Woodhouse Grove School, he passed the London Matriculation Examination with first-class honours at the age of 16. He entered Guy's Hospital, but his health proving unequal to the work, he went to Cambridge where his father, a Wesleyan minister, then resided.

At Cambridge his health improved and he obtained an open scholarship at Downing College, Cambridge. In 1866 he took the B.A. London with an Exhibition in Biology, and in 1867 was in the first-class in the Cambridge Natural Science Tripos. In 1871 he graduated M.B. Cambridge, and in the same year was elected a Fellow of Downing College. He returned to Guy's Hospital, but in 1873, married, and went into general practice at Witham, in Essex. After less than a year Brailey returned to London and took up an appointment at the Moorfields Eye Hospital, where he met Sir William Bowman, and formed a friendship which ended only with the latter's death.

When Mr. Bader relinquished the post of Ophthalmic Surgeon to Guy's Hospital he was succeeded by Mr. Charles Higgens, and Dr. Brailey was appointed Assistant Ophthalmic Surgeon. He held this appointment until the age of 60, when he became Consulting Ophthalmic Surgeon to the Hospital.

In 1885-86 he was Hunterian Professor at the Royal College of Surgeons, and in 1880 took a prominent part in founding the Ophthalmological Society, and at various times filled every office except that of President. In 1890 he was awarded (jointly) the Middlemore Prize by the British Medical Association, and his last distinction was a Honorary Fellowship of Downing College, Cambridge.

Dr. Brailey leaves a widow, a daughter, and two sons, both members of the medical profession who are serving their country; the elder is working with the army, and the younger with the navy.

Dr. Brailey made important contributions to the study of diseases of the eye. He was joint author of Diseases of Iris and Celiary Body, Norris and Oliver's Syst. Dis. of Eye (Philadelph.).

Author of the Anatomy of the Pars Cilaris Retinæ, etc., *Guy's Hosp. Rep.*, 1879; A Theory of Glaucoma, *Roy. Lond. Ophth. Hosp. Rep.*, 1880; Pathology of Sympathetic Disease, *Trans. Internat. Med. Cong. Lond.*, 1881; Sympathetic Ophthalmitis, *ibid.*, Berlin, 1896; On Choroidal New Formations, *Roy. Lond. Ophth. Hosp. Rep.*, 1882; A Theory of Sympathetic Ophthalmitis, *Trans. Ophth. Soc.*, 1884; etc.

EDWARD THOMAS ERNEST HAMILTON,

M.D., M.S. Lond., F.R.C.S. Eng.

We regret to announce the death of Dr. Hamilton which took place on March 8th at his residence in Johannesburg, South Africa. The son of a Naval Surgeon, he was born at Rathgar, near Dublin, in 1867. Entering Guy's in 1886 he became a distinguished student, taking honours in Physiology at the B.Sc. Examination in 1889. He took the Conjoint Qualification in 1891. At London University he took the M.B., B.S. (Honours in Medicine and Forensic Medicine) in 1892; M.D. in 1893 and M.S. in 1895; and F.R.C.S. in 1893.

After serving an appointment as House-Surgeon to Sir H. G. Howse, he became Demonstrator of Anatomy at Guy's, a post he held for four or five years.

In 1898 Dr. Hamilton went out to South Africa and started practice on the Rand. During the Boer War he was medical officer on one of the hospital ships and in various hospitals ashore. After serving with the rank of major in the field during the recent rebellion, Dr. Hamilton became principal Medical Officer at Swakopmund, the chief post of German South West Africa, now in British occupation, where he developed an intestinal complaint, and, being much run down from pressure of work, he was ordered to Johannesburg to recuperate. There he became subject to attacks of mental depression, and it is supposed that in one of these fits he terminated his life, as he was found with a fatal bullet wound in his head.

Much sympathy is felt for his widow, an old Guy's nurse. His funeral took place with military honours.

Change of Address.

H. M. Meyrick Jones, M.D., B.S., Ashfield, Bayshill, Cheltenham.

E. H. Musgrove, Plasynyneen, Cefa Coed, Breconshire.

Fleet Surg. Robley Browne, R.N., c/o Messrs. Stillwell & Sons, 42, Pall Mall, S.W.

Surg. A. E. S. Cheesman, R.N., H.M.S. *Alcantora*, c/o G.P.O., London.

R. W. Murray, Hill House, Ashover.

Norman S. Heegaard Warner, L.D.S. Eng., from Honor Oak Park, to 186, Queen's Road, New Cross Gate, S.E.

Frank E, Rudd, L.D.S., 18, Savile Road, Chapeltown Road, Leeds.

Lieut. O. Parry Jones, R.A.M.C., the Officers' Mess, R.A.M.C. Camp, Eastbourne.

A. Harris, 53, Welbeck Street, W.

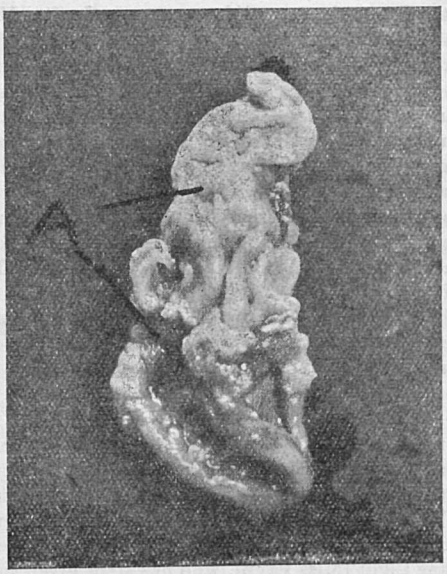
(The Editor will be very glad to receive a post card with notes of any change of address.)

A Case of Neoplasm of the Vermiform Appendix.

Report No. 253, Sir A, Lane, 1915.

Violet Dixon, aged 13, was admitted on March 19th, 1915, into Guy's Hospital under the care of Sir Arbuthnot Lane.

She was admitted for violent abdominal pain which began three days before admission as a generalised tenderness, which got better on the next day and then much worse and much more localised to the right iliac fossa on the third day. Her doctor diagnosed acute appendicitis and sent her up to Guy's, and she was admitted as a case of acute appendicitis. There was a history of previous attacks of a similar but not quite so violent a nature. During the first two days of the present attack there was no constipation. Some six hours after admission the patient's pulse began to rise and her general condition got much worse. Operation was decided on by Mr, J. G. Saner, who opened the abdomen by a long rectal sheath incision.



On opening the abdomen some thin, reddish and foul-smelling pus was observed in the pelvis. A swab of this gave a culture of streptococcus pyogenes longus. The appendix was found to be adherent to the pelvic wall, and to be running in a mesial downward and backward direction. On following the appendix down with the finger Mr. Saner came on what he at first thought was a growth of the rectum with the appendix adherent to it. On dissecting the appendix away with the finger the growth came away with it. The appendix was removed in the ordinary way. Further examination of the ab-

dominal contents revealed no evidence of any other growth, either secondary or primary to the appendicular growth.

After removal the appendix was slit up—the incision dividing the growth which was shown to be white, solid, but easily cut, and extending from the serous to the mucous surfaces of half the circumference of the wall of the appendix. The growth was about half inch by quarter inch in size, and partially obstructed the lumen of the appendix. Just distal to the growth there was a perforation. A portion of the growth was taken, and a microscopic section was cut and subsequently submitted to Dr. Nicholson who pronounced it to be a columnar-celled carcinoma of the appendix. In conclusion I must tender my thanks to Mr. Saner for permission to publish this account, and to Miss Salmon who kindly photographed the specimen. D. H. A. G.

Chapel Report, 1914–1915.

The late Acting Chaplain, Mr. Popham, who resigned on May 1st, 1914, left the chapel services so well arranged that there have been no alterations, except that the Litany is now said once a month after Matins in place of the sermon.

Our organist, Mr. Dennis Brown, having joined the Royal Naval Division, was granted leave of absence for a year, and Mr. Golden, organist of the English Church at Hamburg, has been filling his place. Mr. Dennis Brown's absence has delayed the proposed attempt to form a choir of boys.

The Acting Chaplain has endeavoured to find friends of the Hospital who would undertake to send flowers for the Chapel on one Sunday in each month. There are still two Sundays in the month to be filled. A large sum has been spent hitherto every year in buying flowers, and this money would be useful for other purposes.

There have been many changes amongst those who help in the Chapel. Sister Lorna (Miss Wood), after more than two years' devoted service as Sacristan, has left the Hospital, and has been succeeded by Sister Out-Patients (Miss Coulton) and Miss Hall. Sister Clinical (Miss Moore) felt obliged to give up the arrangement of the flowers on taking over a ward. She was succeeded by Sister Light (Miss Payn), who has since given way to Sister Evelyn (Miss Snelling). Sister Cornelius (Miss Tilbury) has left, and Sister Luke (Miss Fawkes) now looks after the Mortuary Chapel. Sister Job (Miss Marriott) and Sister Luke share part of what was Sister Lorna's work.

In August the Bishop of Southwark conducted a service of farewell for some of our nurses going to the war. He also preached in the Chapel on Ash Wednesday. The Rev. A. L. Preston preached on the Thursdays in Lent.

A Service of Intercession has been held fortnightly at 1 p.m., at the request of the Students' Christian Union.

Chapel Account Fund for Year ending December 31st, 1914.

1914	*Receipts.*	£	s.	d.
Jan.	To Balance brought forward	8	13	11
	Collections—Chapel	51	10	5
	" Bright Ward	9	5	10
	" Box Contributions ...	3	14	11
		£73	5	1

	Expenditure.	£	s.	d.
1914	Flowers, etc.	16	17	4
	Music, etc.	10	5	3
	Furnishing, etc.	6	1	9
	Maternity Samaritan Fund	5	6	7
	Prince of Wales' Fund	3	11	1
	South London Church Fund	5	5	10
	Hospital Sunday Fund	1	17	11
	Balance	23	19	4
		£73	5	1

Audited and found correct,
C. H. WELLS.
March 19th, 1915.

Nursing News.

Matron's Office,
20th April, 1915.

Short leave is now being granted to Nursing Sisters with the Expeditionary Force, and we have lately had the pleasure of seeing Sisters E. Fraser and E. Shackleton.

Miss E. Densham is also in London, and Miss Windley, and all our nurses working at home or abroad are welcome visitors at the Hospital and Institution.

Sister Kiddle expects to be in London this week, and we hope to have the pleasure of meeting her at the Dinner of the Past and Present Guy's Nurses' League, to be held in the Home on Friday, the 23rd.

On Saturday, April 24th, another party leaves Victoria under the auspices of the War Office. Guy's sends five members: Miss Hilliard (lately Night Sister), Miss Cornwall (lately Sister for six months at the British Red Cross Hospital, Netley), Misses Savage and Maddison of the Guy's Institution, and Miss E. K. Roach who has recently returned from New Zealand.

To date, the Present Institution Nurses engaged in War Service are:—

For the War Office.—Sisters Owens, Spedding, Robinson, Barker, Mann, Canter (at Colchester Military Hospital), Nelson, Quilter, Hepburne, Davies, Druce, Warner, Ames, Savage, Maddison.

By the Joint War Committee.—Sister Gibson (in France), Sister Horton (No. 2 General Hospital, Chelsea), Sister Ward (B.R.C. Hospital, Netley), Sister Carpenter (ditto), Sister Gwilliam (in France), and Sister L. Simpson (Clandon Park).

In Private Hospitals.—Sisters Ellis and May (at Abingdon), Sister Bedwell (at Rushton Hall, Kettering), Sisters Pace, Canty, and Von Pein (at Sussex Lodge), and Sister Sewell (at Hadley Wood).

At the Military Wards, Romford Infirmary, Essex.—Sisters Collie, Broome, Sutton, and West.

Miss Gertrude Cannell has joined the Staff of King George's Hospital, Stamford Street.

At Southend the six Institution Nurses are continuing their engagement—Sisters Latham, Blott, Ferdinand, Salter, Sinclair, and Brooks.

In reply to the invitation to attend the League Meeting and Dinner, many letters are received regretting inability to be present. One writer suggests a mighty re-union at the end of the war. "One is always running into Guy's people over here. It is surprising how much comfort one derives from 'another Guy.' It seems to cheer one up for the rest of the day. We absolutely devour the GAZETTE when it arrives for news of all friends."

From Étretat to St. Thomas's Street.—"This is a beautiful little place which we occupy. Sometimes I am afraid it's beauty is a little wasted on us, and we wish that we were nearer to the Gay City. At any rate there is nothing to spend our money on, and we are models of thrifty nurses! I wish you could come and see these wonderful hospitals. Ours has more beds than Guy's. The numbers are really terrific, but all is so well organised you don't realise it's bigness."

From No. 11 General Hospital.—We are not very busy at present, but after Neuve Chapelle had a great rush. We sent out 300 cases and took in 365 in twelve hours, and unfortunately among the bad cases there were 30 deaths in 48 hours. In three days 1,200 patients passed through."

Miss Jolley, writing from an ambulance Train to Matron.—"Thank you so much for your kind card with the view of the dear old Gateway from within. It takes one back in thought to many a happy day, not to say to many numerous rushings through to be on duty in time.

"We are fairly quiet now (April 6th), but we never know what the character of the next train load will be: there may not have been much fighting, but shelling and sniping are constantly going on.

"Fate was kind on Easter Sunday, as, after a busy time there was a lull, and we were able to attend a service in a soldiers' club room, which was originally a barn, and now wonderfully transformed by pretty green hangings all round into a most comfortable building. In the evening the Bishop of London preached, which was a great treat, he was so downright and cheery, and filled everyone with hope and encouragement. As we came out he stood at the door and shook hands with each one. He seems greatly impressed with his experiences out here, as I think we all are, each in our different ways.

"The weather has greatly improved, but there is still a keen wind; however, cowslips and anemonies in the hedges, seen as we pass by, help one to realise summer is on its way. Sister B. Daniels came down to the base on our train last week from one of the clearing stations, and I met Sister Moriarty in the post office at Rouen.

"I expect you have heard that all cameras have been called in; it has caused mingled wrath and grief!"

Miss Ruth Leggoe, writing from No. 2 R.C. Hospital, Rouen, says:—"You will see by the address that I have left the Australian Hospital, and I was very sorry to do so after watching it grow in four months to something like perfection. It really is a splendid place now, with up-to-date appliances, including an X-ray apparatus. I often think of the time when we first went there—no sheets and very low camp beds. The candle-light has now been replaced by electricity.

"This hospital is for officers. Among the present Staff here are five Guy's sisters—Misses Jolliffe, Nation, Masters, and Denny."

Miss F. A. Morgan, writing from No. 11 Stationary Hospital, April 9th, remarks, as many other correspondents do, what a great joy the GAZETTE is, keeping them in touch with so many Guy's people.

"At present I am on night duty here, in charge with three staff nurses. There are sixty beds in a small building; all the rest are in tents. Just lately we have extended to another 240 beds out in a neighbouring field known as the cabbage patch, for they grow thickly right to the doors of the tents on one side. It is really rather nice, though exposed to the winds. In the summer it will be lovely. We have electric lights in all the tents now, and they are well equipped.

"The great amusement for convalescent patients is to make small gardens round the tents, and there is great competition as to which of the 24 gardens is the prettiest.

"The work here is very interesting, but fluctuates very much. It is a case of feast and famine, and, personally, I love the feast and loathe the famine! When we are busy the work is almost too much to

cope with, and then half your patients, chiefly the worst cases are drafted off to England, and you are back to famine again in less than a week.

"Since last October I have been sleeping in a tent, and I have now got one to myself which is absolutely palatial, for I love being under canvas.

"It has been terribly cold and windy, and it is quite exciting work to lie in bed and watch the tent pole rock, and speculate as to how long it will remain standing and what will be the best thing to do if it does blow down. The wet weather is the worst, but you soon get used to finding everything wet and clammy, and cease to worry over it. As a matter of fact, I have been exceedingly well and never even have a cold.

"I was Theatre Sister at No. 9 General when we first started, and had plenty of work. At one time my 'theatre' was a tent, the furniture of which was entirely packing cases and Red Cross boxes.

"Miss Jickling, of Guy's, is now at No. 11, and I often see many Guy's people at Rouen."

From No. 1 General Hospital, Miss Finnis says—

"As I am having a half-day I am trying to pay off some of my debts in the correspondence line.

"Lately the Theatre work has been very heavy, especially after Neuve Chapelle. We had a large convoy of very badly wounded, amputation after amputation. It was really dreadful to see these boys—they are nothing else—lose their limbs one after the other.

"Matron offered me a ward for a time as a change from the theatre, and I was delighted to take it. I am in charge of 50 beds, medical and surgical. Miss Owens is one of the two Sisters working with me. I should have three, but owing to sickness we are short. Misses Sharwood and Strange are on night duty. All the other Guy's are on day duty in the different wards.

"A few days ago a nurse came round in Guy's uniform, and it turned out to be Miss Fox, Matron of the Prince of Wales Hospital, Tottenham. She is now at a French Hospital, not far from here, at Fécamp. We have all had to return our cameras. I miss mine very much, and hoped to send several photos to the Guild Meeting, but we are not allowed to do so."

Papers by Guy's Men.

H. W. Barber, M.A., M.B., M.R.C.P.: Two cases of lupus in children.—*Brit. Med. Journ.*, April 17th, 1915.

N. S. Carruthers, M.R.C.S., L.R.C.P. Acute inversion of the uterus following labour on two occasions.—*Brit. Med. Journ.*, April 17th, 1915.

J. M. Fortescue-Brickdale, M.A., M.D., M.R.C.P.: Multiple lipomata and elephantiasis.—*Ibid.*, April 10th, 1915.

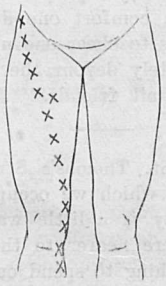
Correspondence.

To the Editor of Guy's Hospital Gazette.

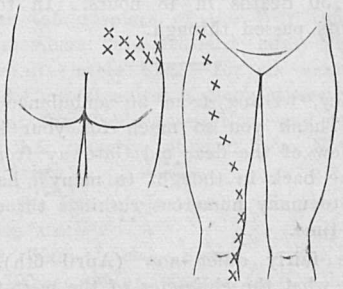
[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—Ed., G.H.G.]

Dear Sir,—The following eight cases of Herpes Zoster, occurring as they did within such a short period of time, and within a radius of three miles, may prove of interest.

1. Mr. B. W., æt. 25, consulted me on January 2nd of this year for intense pain down right thigh of about three days' duration. On examination I found an extensive eruption of herpes running from just below the right anterior superior spine to the inner side of the right knee (see diagram), and corresponding in distribution to the anterior division of external cutaneous, internal and middle cutaneous branches of the anterior crural and internal saphenous nerves.



2. Mr. J. B. R., æt. 38, came to me on January 15th fearing he might have the "itch." He was in no particular pain, but had been "out of sorts" and had had slight twinges of "rheumatism" during the previous ten days. I found an eruption of herpes above the right buttock behind running round to the front and across to the inner side of the right thigh as in the previous case, and corresponding to the distribution of the same nerves and also to the external branches of the posterior division of the lumbar.



3. Miss J. R., æt. 4, child of above. I was sent for on January 28th on account of patient having pain

and irritation around the vulva, following an attack of bronchitis. I found a well-marked vesicular eruption along each labium. Three days later the child developed an atypical rash which I subsequently called modified chicken pox, but there was only one real vesicle, a large one on the back, which scabbed over in the usual manner. The child was very ill, with high temperature and delirium.

4 Mrs. C., æt. 55, consulted me on January 20th for intense pain around the right knee. She had had no sleep for four nights. I found a well-marked herpes corresponding to branches of internal saphenous nerve.

5. Mrs. T., æt. 28, asked me to see her arm on February 10th as she was suffering considerably from pain following an attack of so-called "influenza." On examination, the ulnar side of the left forearm was very tender to the touch and there were about eight or ten well-marked vesicles on the ulnar side of the wrist corresponding to the cutaneous branches of the ulnar nerve.

6. Mr. L. B., æt. 65, consulted me on the same date for pain and a "breaking out" down the front of his right shin. I found about four vesicles just below the knee and on the inner side of the leg.

7. Miss C., æt. 25. I was attending this patient for "neurasthenia" following a slight "feverish cold," and noticed on February 15th a typical eruption of "shingles" on the right side extending round from back to front at the level of the last dorsal vertebra.

8. Mrs. C., æt. 46, a friend of my wife's, came to stay with us on February 15th. On February 24th, after a slight neuralgic headache, she appeared with the typical vesicular eruption at the outer canthus of her right eye, corresponding to the terminal branches of the malar nerve.

All these cases made uneventful recoveries with the exception of the sixth case. This man has still a good deal of pain down his right leg.—I am, yours faithfully, JOHN N. WATSON.

Wootton Bassett, Wilts.
March 21st, 1915.

Dear Sir,—Since last writing to you I have to record the sad death of Major Hamilton who shot himself at Johannesburg just over a fortnight ago, during a fit of temporary insanity. He spent an evening in my cabin and was very interested to hear all the news concerning Guy's that I was able to tell him. He was always cheery and universally popular in Johannesburg, and he was considered one of the smartest all round men, professionally, in South Africa. As he was contemporary with and well known to most of the present members of the Staff, I am sure they will hear this news with regret. It is a strange coincidence that Hamilton and Rosie Bryant, both brilliant men, should have lived together, and both have met their fate in the same manner.—Yours truly, IDYYEPS.

P.S.—I have come across Edmeades and Murray, both old Guy's men, serving with the forces out here.

Cape Town, April 1st, 1915.

A Chainless Soul.

In the world of might and action in which we live to-day there is little place for the cultivation and enjoyment of art, for Truth is now clothed in garments so strange that we fail to perceive her beauty. It is admitted by many that it is difficult to read, and during the past six months, with the exception of a few verses evoked by the war, the voice of literature has been strangely silenced.

In other times the publication of the poems of the three Brontë sisters, with those of their brother Branwell, edited and introduced by Arthur C. Benson, would have attracted some little notice, but only a few short reviews have appeared. No doubt the feeling has been that the message of this simple, lonely, and introspective family was on a plane too remote from our present problems to be of interest or value, but as action must ever spring from thought, the true poet has always an undying influence upon succeeding ages.

Mr. Benson, in his short introduction clearly apprises the differing value of the poems. Charlotte Brontë's gift was for poetical prose, and in her verse there is little inspiration or originality. Anne's mind was clouded by the despondent orthodoxy of her day, and her religious faith evolved by struggle which failed to find in poetry an appealing medium of expression. The catastrophe of Branwell's life and the hurried decay of his talent cannot, in Mr. Benson's judgment, destroy the fact that he possessed the true artistic vision, and he would class his instinct for poetry with that of Emily, the greatest genius of the family.

That their genius can claim the right to teach is not denied, and that it sprang from the deep things of life, Mrs. Humphry Ward very beautifully expresses in some lines written in 1900 and published by her in a magazine. As they are not generally known, it may be of interest to quote them :—

"The Brontë Sisters."

"Pale sisters, children of the craggy scree,
Deep dale, and murmuring moorland, where ye plied
All household arts, meek, passion-taught and free,
Kinship your joy and fantasy your guide.

Ah, who again mid English heaths shall see
Such strength in frailest weakness or so fierce
Behest on tender woman laid, to pierce
The world's dull ear with burning poetry?
Whence was your spell? and at what magic spring,
Under what guardian muse drank ye so deep
That still ye call and we are listening,
That still ye plain to us and we must weep?
Ask of the winds that haunt the moors what breath
Blows in their storms, outlasting Life and Death."

The study of Emily's verse reveals a passionate love of nature, shared by the family, and one cause of the profound nostalgia from which they all suffered when parted from their familiar moors. The nature they knew was bleak and gray, relieved only by rocky dells and heather, and in spring by bluebells, which give unwonted colour to northern lands.

"What have those lonely mountains worth revealing?
More glory and more grief than I can tell.
The earth that wakes one human heart to feeling
Can centre both the worlds of Heaven and Hell."

In company with all who wander on high places, her fancy also spent itself upon clouds and winds and sky. To her storm-tossed soul the peace of night, with its attendant lights, brought dreams and visions and re-union in spirit with those she loved.

"A messenger of hope comes every night to me, . .
He comes with western winds, with evening's wandering airs,
With that clear dusk of heaven that brings the thickest stars.
Winds take a pensive tone and stars a tender fire,
And visions rise, and change, that kill me with desire."

"STARS."

Ah! why, because the dazzling sun
Restored our earth to joy
Have you departed, every one,
And left a desert sky?

I was at peace, and drank your beams
As they were life to me; . . .
Why did the morning dawn to break
So great, so pure, a spell? . . .

Oh, stars and dreams, and gentle night;
Oh, night and stars, return!
And hide me from the hostile light
That does not warm, but burn.

That drains the blood of suffering men,
Drinks tears, instead of dew;
Let me sleep through his blinding reign,
And only wake with you!

Our interest to-day will centre on the attitude of the sisters to life rather than to nature, and here we find a remarkable similarity between the phraseology now applied to nations and masses of men and that used by these lonely women to describe the conflict of their spirits with the forces arrayed against them. As Mr. Benson says, "their conception of duty and purity was grimly passionate, and with all their sensitiveness and susceptibility they kept an unflinching hold upon a high and fearless morality."

Anne was content to

"gather fortitude from pain,
And hope and holiness from woe."

But Emily, haunted by the limitations of life, defied and questioned fate.

"No promised heaven, these wild desires could all, or
half fulfil;
No threatened hell, with quenchless fires, subdue this
quenchless will!

They sang of honour, courage, and devotion. Physical pain, separation, and the tragedy of their brother's life left them unconquered. Above all, they fought for liberty, liberty of thought and spirit.

"The only prayer
That moves my lips for me
Is, 'Leave the heart that now I bear,
And give me liberty!'
. . . In life and death a chainless soul
With courage to endure."

We answer "Amen." S.

Guy's Hospital.

Dispensary Memorandum.

Carbolic Acid costs four times as much now as it did last year, and for the sake of economy Cresol and Soap (formerly known as Lysol) solution should be used in its place. The cost of Cresol Lotion is only $\frac{1}{16}$ of the cost of a corresponding amount of Carbolic Lotion.

Soluble Cresol will now be called *Antiseptic Cleaning Fluid*, and the supply of it will be resumed. It should take the place of Lysol for all cleaning purposes.

Soap Solution. This is supplied by the Dispensary solely for medicinal uses, and should not be employed for ordinary cleaning.

RELATIVE COST OF THE CHIEF ANTISEPTIC SOLUTIONS.

Boric Acid	(1 in 25)	...	6
Carbolic Acid ...	(1 in 20)	...	32
Cresol and Soap (formerly called Lysol) ...	(1 in 50)	...	2
Formaldehyde Solution	(1 in 250)	...	1
Hydrogen Peroxide...	(5 volumes)	...	30
Mercuric Chloride ...	(1 in 1000)	...	2

H.F.—E.C P.

April 10th, 1915.

Cancer of the Cervix.

A CLINICAL LECTURE BY HAROLD CHAPPLE, M.C., F.R.C.S.

Gentlemen,—There is no necessity to precede my remarks by any apology for addressing you on such an every-day topic as Cancer of the Cervix. The very frequency of its occurrence and the appalling nature of its uninterrupted course demand of us that our knowledge of this subject should be as complete as possible. The ghastly pictures of the closing stages of this condition are doubtless only too familiar to you all and their horror is increased in that they represent a failure not only of our treatment, but of our system of education. Cancer of the Cervix is at first a curable disease and in its earliest stages the radical removal is attended by the happiest results. To what then are we to attribute the fact that in the great majority of cases the condition is a hopeless one when we meet it in the outpatient department. I think it is mainly due to three factors:—

1. That the early stages of the disease are accompanied by only slight signs.

2. That these signs are usually only irregularities of normal phenomena in women and so are disregarded by them and very frequently by their medical attendants.

3. The repugnance with which so many women regard the suggestion of a pelvic examination.

If we are to get the cases sufficiently early for removal to be possible and the prognosis to be good, these facts must be common knowledge not only of the medical profession but of women themselves who under such circumstances should be fully aware of the urgency of submitting themselves to an examination.

It has been stated that a dissemination of these facts would cause much misery by needlessly alarming many women. Nothing could be more absurd. It is a comparatively simple matter to tell a woman she has not got carcinoma of the cervix, whereas in the present state of our knowledge it is impossible to relieve her of the condition when once the disease has spread at all widely.

As far as I can see, the only hope that we can have of dealing with this great problem with any measure of success at present is that all women of mature age should not only realise, but having grasped the fact should act upon it, that an irregular hæmorrhage however slight in an adult woman, more especially if she has borne children, is not a normal occurrence and cannot be disregarded without a thorough investigation. Palliative measures such as the giving of ergot and the use of douches to such patients without insisting on a thorough vaginal examination are absolutely unjustifiable when we know that such slight signs so frequently indicate an early carcinoma. If the woman has carcinoma the sooner it is dealt with the better, and the mere ignoring of the symptoms will not go far towards ameliorating her lot. It is simply throwing away the one opportunity she has of being cured. There seems an almost incredible desire on the part of many people to keep women in ignorance of their phenomena, with the idea that such knowledge tends to a lack of modesty and a morbid interest in things that had better be ignored. This is a most pernicious system of education. Naturally these are not topics for general discussion on all occasions, but there must be many opportunities of imparting knowledge that would be of the greatest utility, and the sooner such occasions are made the better. I believe it is only thus with our present ignorance of the causation of this disease that the heavy death-roll from it will be materially altered.

Carcinoma affects the cervix either as a squamous-celled growth which begins on its vaginal aspect, or as a columnar-celled growth originating in the cervical endometrium. I have brought you here specimens that I have removed in Queen Ward, and they will serve to illustrate the types of growth. Clinically it appears on its vaginal aspect as an ulcer with raised everted edges which erodes the tissues or less frequently as a warty excrescence. It also may affect the cervical canal in any portion of its length, but it is more likely to affect the lower half, and here appears either as an eroding ulcer or as a cauliflower-like growth. By these the cervix is destroyed, and soon the growth begins to invade the surrounding tissues, spreading laterally in the tissues in the bases of the broad ligaments, forwards to the bladder, backwards along the utero-sacral folds and to the rectum, upwards to the internal os and at times downwards on the vaginal wall.

It occurs most commonly in women between 40 and 60, but it may occur and is not at all uncommon under 30. Only recently we have had in Queen Ward a woman of 26 with an extensive growth. This tendency to occur round about the menopause is a very unfor-

tunate one, as a woman is all too ready to attribute an irregularity at this time to the "change of life," and the invaluable weeks slip by before the persistence of the hæmorrhage or the discomfort of the discharge compels her to seek medical advice. It is almost exclusively confined to women who have had children, and the tendency is somewhat increased by the number of children.

As I have said before the early indications of the disease are unfortunately often slight. The first one is usually hæmorrhage which has no relation to the normal monthly period. The bleeding is produced by any mechanical irritation of the affected part, and so is noticed after coitus, the introduction of the nozzle of a douche, and so on. It is usually only slight and does not at first persist, and hence is too often disregarded. The other early symptom, which usually is noticed subsequent to the hæmorrhage but which may precede it, is a brownish watery discharge. It comes from the ulcerated surface of the growth.

Pain is altogether absent at the onset of this condition. This cannot be too strongly insisted upon. So often is one met with the remark that the absence of pain was the reason for refraining from seeking medical advice. The appearance of pain usually coincides with the involvement of the connective tissue round the cervix, although it may be due to other causes.

Again, loss of weight is not an early symptom, and carcinoma of the cervix is frequently seen in quite stout people. This point also is to be borne in mind as the possibility of carcinoma is often apparently not suspected because of the absence of this sign. It is, of course, as elsewhere in the body, a late symptom, and by the time cachexia is well marked the condition is usually hopeless.

Later, as the growth continues to increase and spread, portions of it become gangrenous and an unpleasant discharge results. Branches of the uterine arteries are frequently eroded and a profuse hæmorrhage takes place which renders the patient anæmic, or smaller vessels may be opened and an irregular loss of blood result. Infiltration of the bladder may follow with its resultant frequency of micturition, and later a fistulous opening may result, so that the urine is continually discharged through the vagina.

The lateral spread in the bases of the broad ligaments naturally involves the lower ends of the ureters which may become partially obstructed and enlarged behind the obstruction and a hydronephrosis results. Infection is then superadded and a condition of ascending nephritis brought about. This is a very common occurrence.

Posteriorly, the spread takes place along the utero-sacral folds and in the connective tissue around the rectum, which may be invaded and opened and a recto-vaginal fistula result, so that fæces escapes through the vagina.

The lymphatics run to glands that are situated along the external and internal iliac vessels and on the lateral surface of the anterior aspect of the sacrum. When the abdomen is opened, except in advanced cases, the glands on the internal and external iliacs are those that are found to be affected, and the affection of the lymphatics is usually confined to the pelvic glands, and the secondary deposits which are so frequently met with in many other malignant affections are not common with cervical cancers.

One great reason for this is that the disease under consideration is usually comparatively rapidly fatal, and the rapidity is largely due to the anatomical position. That is to say, the commonest cause of death is an affection of the urinary tract, and this is made possible by the close proximity of the bladder to the ureters. Repeated profuse hæmorrhages with their sequelæ also may produce a fatal result, and they are caused by the opening of the branches of the uterine vessels which lie so closely to the cervix. One of these events is likely to happen comparatively early so that it gives little time for free dissemination via the lymphatics.

Other modes of death are, of course, possible, but are not nearly so common. The obstruction to the cervical canal may cause a retention of the uterine secretions, and these becoming infected a pyometer results, or the fallopian tubes also become affected and pyosalpine results. This is a source of danger, in that it may perforate or leak into the peritonium and set up a peritonitis. Again intestinal obstruction may be caused by the adhesion to the growth of a piece of small intestine and so on.

I have merely outlined this aspect of the subject and dealt with some of the more important points, as naturally the diagnosis and treatment interest you most.

The diagnosis can only be made by a vaginal examination as there are no symptoms whereby we can exclude it. It may be that some day we shall have some serum reaction whereby a pelvic examination can be dispensed with, but at

present there is none such, so whenever carcinoma is to be suspected by some unusual hæmorrhage this must be insisted upon, and the gravest responsibility rests on the treatment of such a case by futile douching and the giving of drugs without first excluding the presence of a carcinoma by an examination, which at its worst is only unpleasant and is surely to be compensated for by the knowledge that will thus be gained.

In early cases the examining finger will detect a nodular surface or a small ulcerated surface whose characteristics are that it is friable and breaks away on the finger, hæmorrhage being thereby caused. If this be compared with the unaffected portion the difference will be obvious. In the ulcerating types the finger frequently passes into a rough cavity whose edges are everted and easily broken down causing free hæmorrhage. There are practically only three conditions that may simulate this.

1. *Syphilitic chancre*, which is so rare as to be almost negligible. Its nature will soon be made manifest by the secondary symptoms that follow. In any case an early diagnosis is usually not made except by the microscope.

2. *Tuberculous ulceration.*—This is not nearly so common, and the differential diagnosis will usually require the microscope.

3. *Erosion.*—This imparts to the finger superficially a soft feeling, well described as velvety, whereas the deep tissues often are very hard. It is not friable, and although it bleeds the hæmorrhage is not nearly so free as in the case of cancer, and no particles of growth come away on the examining finger.

With a speculum the appearance of the cancer varies with the type of growth, and one sees either a proliferating portion which looks a dull red colour and is raised from the surface, or an ulcer which bleeds easily when touched, and which has raised everted edges, which are quite unlike the definite edge of an erosion. If there is any reasonable doubt a piece of the tissue at the edge of the growth should be removed and microscoped. It is best to include a little apparently healthy tissue underlying the growth.

This can be done without anæsthesia, as the cervix is almost insensitive and can be drawn down with a tenaculum and the piece removed If bleeding is thus produced a gauze pack will usually suffice to arrest it. Otherwise it can readily be undersewn with a catgut suture.

In the later stages the diagnosis is usually all too obvious, and there is nothing that really resembles the condition except perhaps a sloughing fibroid. Here, again, the microscope will quickly settle any doubts.

As regards the treatment, as far as we know at present radical removal is the only means whereby a cure can be effected, consequently when the growth can be removed it should always be done. There are for this purpose two methods of attack—the abdominal and the vaginal routes. Believing, as I do, in the transplantability of cancer from one part of a patient to another, whenever it is possible the abdominal route is the method I adopt. By this route it is possible not only to get rid of the growth but of the cellular tissue surrounding it in which the lymphatics run and all the glands are removed along both the iliac vessels from the obturator foramen to the junction of the common iliacs on either side. This specimen shows how completely this can be done. It also illustrates how much more freely the growth can be removed, for if you will feel in the cellular tissue removed there are two small nodules of growth which must have been left by any other method. The specimen was removed two and a half years ago, and when last heard of the patient was doing very well. The removal by the abdominal method is of course more difficult, and it is urged that the shock is much greater. This shock can be successfully combated by the use of modern methods, and in the last fifteen cases that I have removed by this method only one has died, and in her case the condition was complicated by a pregnancy in which the child had first to be removed by Cæsarian section which was accompanied by a considerable loss of blood owing to the anterior situation of the placenta.

Now as regards those cases which we consider unsuitable for radical removal. What is to be done for them? Are we simply to tell them that we can do nothing and leave them to those awful remaining months of their existence? Or can we do anything that will help to render the remainder of their lives more bearable and rob it of most of its horrors, although we cannot promise them a cure?

In what I would call the early stages of inoperability we can do a great deal. There are three things to be dealt with:—Hæmorrhage, foul discharge, pain, and in a sensitive woman the fear that at any moment the hæmorrhage may become profuse and that she may bleed to death, and the presence of a foul stinking dis-

charge are usually quite sufficient to make her life an almost intolerable burden. What then can be done? The abdomen is opened in its lower segment and the ovarian vessels tied and the ovaries removed. Then the internal iliac arteries are exposed and ligatured securely. The ureters are dissected out and freed along their pelvic length, and then the glands are dissected off the iliac vessels en masse on both sides, reaching from the obturator foramen to the bifurcation of the aorta. The peritoneum is then restored and the abdomen closed in the usual way. Ten days later the patient is turned into the lithotomy position, and the mass removed with a sharp spoon. There is now no hæmorrhage and the scraping process can be most efficient. I have been able to demonstrate this in a very striking manner on a patient whom we took into the Ward, and who had had a profuse hæmorrhage in the Surgery.

After the vessels had been ligated, the most thorough scraping out of the cervical mass produced no hæmorrhage and she had not bled again when last seen.

The opportunity is now taken of treating the edge of the growth with diathermy. I have had the benefit of Dr. Iredell's skill in this part of the treatment. We are convinced that the cutting off of the blood supply and the possibility of scraping away the centre of the growth and thus permitting the growing edge to be treated by the diathermy is of great value. Clearly its effect must be greater when applied in that way than if its action must take place through a thick necrotic mass. It is known that the cancer cell is more easily destroyed by heat than is the living cell, and the results obtained have been most satisfactory. The patients have left the hospital feeling perfectly well and quite ignorant of their condition. The hæmorrhage is controlled, the discharge is absent and the pain is certainly later in its appearance, and although no claim is laid to having cured an inoperable carcinoma, some of the results have been most striking.

The following case illustrates the value of the procedure :—

Mrs. A. O'C., æt. 36, was admitted under my care on October 26th, 1914. She complained of severe irregular hæmorrhage and considerable pain in the back. She was found to be suffering from a carcinoma of the cervix which was too extensive for removal. Her abdomen was opened, and her ovarian and internal iliac arteries were ligatured. The middle sacral artery was of no importance. All the glands along both groups of iliacs vessels were dissected off from the obturator foramen to the bifurcation of the aorta, and the glands along the lateral borders of the anterior surfaces of the sacrum were also removed. The ureters were freed in their pelvic course. The peritoneum was sewn over and the abdomen closed in the usual way. On November 9th she was again anæsthetised and the cervical mass scraped very thoroughly away and diathermy applied. She has since had several applications as an outpatient under Dr. Iredell in the light department and when she reported herself at my outpatients on Monday last, April 19th, she felt perfectly well, she had had no more hæmorrhage or discharge and no pain.

Appointments.

Civil.

Frank E. Rudd, L.D.S. Eng., has been appointed House-Surgeon to the Dental Department, Leeds Public Dispensary.

A. H. B. Kirkman, F.R.C.S., Eng., has been appointed Certifying Surgeon under the Factory and Workshop Acts for the Staplehurst District of the County of Kent.

G. Bellingham Smith, M.B., B.S., F.R.C.S., has been appointed to represent the Royal College of Surgeons on the Managing Committee of the British Hospital, Woolwich, for Mothers and Babies.

Royal Army Medical Corps.

The following Captains to be Majors :—D. P. Watson, A. C. H. Gray, J. E. Powell, S. L. Pallant, M. O. Wetherell, R. L. Collins, A. C. Osburn.

To be temporary Lieutenant :—H. B. German.

3rd Southern General Hospital.—The undermentioned officers are seconded under Paragraph 112, Territorial Force Regulations :—Major John A. P. Price, Capt. N. B. Clowes, Capt. W. B. Secretan.

The undermentioned has been granted temporary rank whilst serving with the field ambulances of the Welsh Division :—As Lieut.-Col., Capt. T. P. Thomas. Lieut.-G. A. Blake to be Captain, dated March 30th.

Attached to other than Medical Units.

G. W. C. Hollist (late Surgeon Royal Navy) to be Lieutenant.

Naval.

Royal Naval Volunteer Reserve.—Temporary commissions in the R.N.V.R. have been issued as follows:—Dental Surgeons, C. Glover, F. W. Paul, H. J. Corin.

Colonial Medical Service.

West African Medical Staff.—C. H. Tipper, M.R.C.S., L.R.C.P., L.S.A. Lond., has been promoted to Senior Medical Officer, Nigeria. C. D Ralph, M.R.C.S., L.R.C.P., to be Senior Medical Officer, Gold Coast.

Note on some old Guy's Hospital Pharmacopœias.

According to the preface of the present edition of this work the first issue was published in 1791. There is a copy in the library which has the added interest in being bound with the Pharmacopœia of St. Thomas's Hospital of 1787. As the title page states, the book is in accordance with the Pharmacopœia of the Royal College of Physicians of London which at that time occupied the official position that the British Pharmacopœia does at present.

The first eighteen pages are devoted to the enumeration of the botanical and zoological sources of the articles used in the rest of the book. Next come the preparations and compounds among which we find the *Bolus* occupying quite a prominent place, there being no less than twenty-three different kinds. The bolus was apparently of no fixed size, some being thirty, others fifty grains in weight. There is nothing to show if it were intended to be taken in one dose or a little at a time, indeed the indications are in favour of the latter view, for each calomel bolus contained ten grains, unless calomel of that day were a less pure or less active article than it is to-day. The excipient employed to stick the ingredients together was very often syrup or syrup of ginger. Confection of orange of the London Pharmacopœia of the following tasty formula was also often used:—

CONFECTIO AURANTIORUM.

R/.

Aurantiorum Corticis exterioris recentis,
radulâ separati, libram.
Sacchari purificati libras tres;

Corticem, in mortario lapideo, pistillo ligneo contunde; tum, adjecto Saccharo, iterum contunde, donec corpus unum sit.

An interesting link with the past is afforded by the survival in the Dispensary of the vessels in which these boluses were stored. They are of about the capacity of two quarts, and appear to be made of pewter.

Among other preparations we note the *Julep*, which does not differ from the mixture, although both were in vogue, Julepum Ammoniæ, being practically the Mistura Ammoniæ at present in use. The present Lotia Rubra is represented by the Lotio Zinci Vitriolati, and another interesting formula is that for Oleum Camphoratum, which is given in full because it had not yet been adopted by the London Pharmacopœia. It would be very interesting to know if the first appearance of this formula for the modern Linimentum Camphoræ first saw the light here or if it were merely adopted from some other source.

Taking a general view of the whole, one is struck with the extreme simplicity, not to say meagreness, of the formulæ. In accordance with the knowledge then available, most of the drugs are derived from the vegetable world. There are only a few mineral substances, *e.g.*, 3 of antimony, 7 of mercury, 4 of potassium, and about the same number of preparations of sodium. One notes the absence of the alkaloids, which at that time had not been discovered, nor had the important class of artificial substances, for which medicine is indebted to the organic chemist, and of which chloroform and the salicylates may be taken as examples. Ether was known and was used internally, but judging from its dose, a gtt. xxx. ad c., it was evidently contaminated with a fair amount of alcohol. One of the three linctuses, Linctus Boracis, is very similar to the Mel Boracis still official.

Second Edition.

As far as is known to the writer the only official list of the various editions is that in the preface of the G.H.P., referred to above. There it is stated that the second edition was published in 1837. It seems unlikely that the long period of forty-six years would elapse between the two editions. Some time ago in looking through an accumulation of rubbish in the Dispensary a copy of an edition published in 1826 came to light. This has the following title-page:

PHARMACOPŒIA

IN USUM

NOSOCOMII

A

THOMA GUY, ARMIGERO,

PROPRIO SUMPTU

Ante Obitum Fundati,

ET

Maxima ex Parte Conditi:

HENRICO JACOBO CHOLMELEY, M.D.
GULIELMO BACK, M.D.
RICARDO BRIGHT, M.D.
HUJUSCE NOSOCOMII
MEDICIS,

THOMA ADDISON, M.D.
PRO-MEDICO,

ASTLEY PASTON COOPER, Baronetto,
CHIRURGO CONSULENDO,

CAROLO ASTON KEY,
JOHANNE MORGAN,
BRANSBY BLAKE COOPER,
CHIRURGIS,

THOMA CALLAWAY,
PRO-CHIRURGO,

RICARDO STOCKER
PHARMACOPŒO.

And on the next page:

PRÆSIDI,

THESAURARIO,

CÆTERISQUE CURATORIBUS,

NOSOCOMII,

HANCCE PHARMACOPŒIAM

SUMMA OBSERVANTIA

D. D. D.

MEDICI,

CHIRURGI,

ET

PHARMACOPŒUS,

QUARTO IDUS APRILES,

MDCCCXXVI.

This copy evidently belonged to James Stocker, the son of Richard, who was the last holder of the position of Apothecary at Guy's, and it was apparently his desk copy. He it was who was "damned with faint praise" in Wilks and Bettany's *History of Guy's Hospital.* In those days it was necessary to ensure its safety by writing in various parts of the work "this belongs to Guy's Hospital." (One must record that similar precautions are still necessary.)

Bound with this copy is the London Pharmacopœia of 1824, which was made official by the Court held at *Brighton* at which, among others, the Duke of Wellington was present.

The following quaint extract may be given from the proclamation:

Whereas . . the said President and College have with great care, pains and industry, revised, corrected, and reformed a Book by them formerly published, intituled *Pharmacopœia Collegii Regalis Medicorum Londinensis,* prescribing and directing the manner of preparing all sorts of Medicines therein contained, together with the true weights and measures by which they ought to be made. . . His Majesty doth strictly require charge and Command all and singular Apothecaries and others, whose Business it is to compound Medicines or Distil Oils or Waters, or make other Extracts within any part of His Majesty's Kingdom of Great Britain called England, Dominion of Wales or Town of Berwick upon Tweed that they and every of them . . . . do not compound or make any Medicine or Medicinal Receipt or Prescription or distil any Oil or Waters, or make other Extracts that are or shall be in the said [Book] . . . in any other manner or form than is or shall be directed, prescribed and set down by the said Book, and according to the Weights and Measures that are or shall be therein limited except it shall be by the special direction of some learned Physician in that behalf; And His Majesty doth hereby declare that the offenders to the contrary shall not only incur His Majesty's just Displeasure, but be proceeded against for such their Contempt and Offences according to the utmost severity of Law.

Besides the above copy, which is of great interest to Guy's, and is now in the Wills Library, another copy of the same edition has been brought to my notice by the Librarian of the Pharmaceutical Society. This formerly belonged to W. Curry and apparently also to A. B. Middleton. It is in the hope that copies of this and possibly other editions of the G.H.P. may come to light that the present notes have been written.

Among the new drugs introduced in this edition one notes quinine sulphate which had been discovered some six years earlier. The edition is also interesting in containing for the first time a pill which has become famous and is associated with the name of Addison. Pilulæ Digitalis Compositæ, as it was then termed. This contained half a grain of digitalis leaf, one grain of squill, and two grains of extract of hyoscyamus, to which one was directed to add occasionally (*interdum*) half a grain of calomel. This pill was omitted from the 1837 edition, but had reappeared in that of 1868 (I have not seen copies of the editions of 1851, 1855, 1864), under the name of Pilulæ Diureticæ cum Hydrargyri Subchlorido, the calomel being then incorporated in the formula. In 1879 mercurial pill replaced the calomel, and its name was altered to what it is at present. It may be stated, in passing, that the B.P. Codex has adopted this formula, and gives Guy's Pill as a synonym, but the extract of hyoscyamus has been left out.

Another interesting mixture, but not much used nowadays, is that of Balsam of Peru. As the directions stand in the current G.H.P. it is impossible to make this mixture into an emulsion, as it should be made. The trick is simple: all that is required is to use a little heat, and this was apparently known to the compilers of the 1826 edition, the directions stating that the mortar must be previously warmed and that the water must be added at 110°.

To show the wonderful attention to details which characterised the compilation of this work, one need only instance that it contains a table showing the correct pronunciation of all the medicinal substances in use; from this we learn that the accent on ætheris and æthereus respectively is on the first and second syllable.

Very little remains to be said of the succeeding editions. Following the example of the B.P., the English language was adopted in the 1868 edition.

Perhaps it may not be out of place to refer to the history of the well-known Mistura Acidi Composita, which is quite a modern, having been introduced in the 1879 edition. For its age it has undergone many alterations; most people say of it, that like *Punch*, it is not so good as it used to be. Certainly it has been shorn of much of its alcohol, and all its cardamoms and sugar, so that it must be admitted that it is now the mere ghost of its former self.

H. FINNEMORE.

Guy's Hospital Gazette Museum of Antiquities.

THE CURATOR'S ANNUAL REPORT TO THE GAZETTE COMMITTEE.

According to the signature book 171 students and others have visited the Gazette Museum of Antiquities since it was opened in June, 1913. No doubt the number of names would have been larger if every visitor had signed his name on the special occasions when the Museum was thrown open to everybody.

The collection comprises antiquities discovered from time to time in the various excavations upon the hospital site—Roman jars, a 12th century bas relief from the Abbot of Battle's Maze, and bellarmines, clay pipes, etc., from the plague pits. Besides these there are a series of about 20 views of the hospital at different periods, some finely engraved certificates issued by the School in the early 19th century, a few portraits of former members of the Staff, and a couple of autographs of Thomas Guy.

The Gazette Museum of Antiquities has to thank the authorities of the Hospital for recently arranging for the deposit in the Museum, among other objects, of two of very special interest, viz., Thomas Guy's Walking Stick and Gold Ring. These have been placed in the glass show case and secured with locks. With these additions the show case is now full, and a second case of a similar kind is urgently needed for future additions.

There are also several unframed photographs, etchings, etc. May I suggest that they be framed and suspended from a brass bar, instead of the ordinary picture fittings? A catalogue, giving a description of the various articles in the Museum is in course of preparation and will be ready shortly.

In conclusion, I should like to say how much impressed I have been by the number of students who, through the Museum of Antiquities, have been led to take an interest in learning more about the history of the Hospital.

J. H. E. WINSTON,
Wills Librarian and Curator of the Museum of Antiquities.

March 18th, 1915.

Vignettes from France.

VII.

We called her "Bébé," a pretty little girl of about fifteen, and as we had billeted with her parents for a week, we had come to know her very well.

Now, her parents had been forced to leave their home, the "libraire" of the Belgian village, and they had come back to the village behind theirs when the whole of the line in front of us had retired, leaving their house just inside our lines. In the meanwhile, they and Bébé lodged with some friends and begged to be informed when it would be safe to go back home.

After about a week they became tired of lodging, and as our lines had gone forward again a few hundred yards, they returned for a day. But they soon had to go into their previous lodgings as the Germans busily shelled their village with shrapnel. After that we saw Bébé every morning, and she would greet us with a smile and ask when we were going forward again, as they had decided to wait until the transport moved into their own village before they made another move. Besides, Bébé had had enough of shells, one of which had killed a nun close to where she was standing. So she waited with us, and if we inquired when she was making the journey again she replied that it would be "next week," in place of the "to-morrow" that it had been when we had first retired.

At the end of a fortnight she was getting rather tired of it, and we did not see her so frequently, but when we met her she always had high hopes of being home again soon. She had great faith in the English.

Soon after this the Germans recommenced to shell her village with renewed vigour, and the convent with the chateau close to it just outside the village were in flames. At night the Germans made a heavy attack, and our lines were still further pushed back to a position just behind the village, which the Germans now held. Our artillery accordingly shelled the village vigorously, with the result that what the Germans had left was soon destroyed, including Bébé's home!

All this could easily be seen from a high hill where there was every day a small crowd of villagers from all round looking at the panorama of battle spread out before them. Not that there was much to see—an occasional shrapnel and various columns of smoke, but Bébé heard that her home had been burnt. After that we didn't see her at all. I fear that she had lost most of her faith in the English.

Books, etc., Received.—The Prescriber, New York State Journal of Medicine, The M.S. Journal, The Hospital, The Nursing Times, St. Bartholomew's Hospital Journal, The Dental Elevator.

The Nature and Seat of Fatigue.

A Paper read before the Guy's Hospital Physiological Society by J. JOFFE.

There is no need to define what is meant by Fatigue: it is familiar to each of us, in some as mental fatigue, in others as bodily fatigue. Although these two classes of fatigue may at first seem essentially different, I will show later how one may influence the other.

In dealing with so large a subject as fatigue it will be necessary to adopt some plan. We may either start with the cerebral hemispheres and tract the phenomenon of fatigue in a descending direction or we may commence at the periphery, *i.e.*, muscles and glands, and trace the same processes towards the master tissue of the body. As it is possible to experiment on a muscle or a gland separated from the living entity, whereas experiment on a separated cerebrum has never been realised, I will adopt the latter plan.

It is comparatively easy to show that a muscle is fatigued if it is stimulated for a sufficiently long interval of time at a sufficiently rapid rate. To my mind the experiment as usually performed is not conclusive. A muscle is taken and fatigued, *i.e.*, stimulated till it gives no response. It is then assumed that fatigue has set in. In the muscle there are three distinct bodies. There is, firstly, the nerve ending, then the muscle substance proper, while connecting the two is the intermediate substance of Langley. We know little or nothing about its chemistry and histology, except that it can pick out between optical isomers, and may be represented by the muscle plate, but that it exists there can be no doubt if one remembers the action of curare and nicotine on the denervated limb of a fowl and the work of Keith Lucas concerning characteristic of a denervated muscle. In a fatigued muscle, then, we do not know which of these three elements is fatigued. If we previously stimulate the nerve to the muscle until the muscle no longer responds, we can eliminate the nerve ending. There is no reason to assume that the actual axons in the muscle differ in their relationship to successive stimuli, from the nerves of which they form part; this eliminates the seat of fatigue from the axons within the muscle. We are now left to decide whether the intermediate substance or the muscle substance proper is the seat of fatigue. As we know less about the intermediate substance than the muscle, a consideration of the properties of the latter will more readily lead us to a decision. We can experimentally show by the trouser experiment that the nerveless ending of the sartorius is directly responsive to stimuli. If, then, we suppose we have fatigued the muscle plate, it would be logical to assume that the muscle would still respond to stimuli, there being no evidence that the nerveless free ending of this muscle is different from the protoplasm of any other muscle. We have, then, more or less located the seat of fatigue in a muscle in the muscle substance proper. There can be no dogma on the above point. If a muscle be stimulated with single induction shocks till fatigued, it may then respond to greater stimuli. Let us make the assumption that the intermediate plate was fatigued; we would then conclude that if the muscular protoplasm were still capable of responding, a larger stimulus would be needed to produce a contraction, because the muscle is the last substance in the chain, nerve, nerve ending, intermediate substance and muscle, and has the smallest irritability of these four substances. The irritability of the intermediate substance has been determined indirectly by Keith Lucas. He has shown that the characteristics of different tissues, as measured by his rheotome, are proportional to their irritability as determined directly with an induction coil. We must, therefore, remember that although it may be the muscle substance itself that is fatigued, there is a possibility that the intermediate substance plays a part in the fatigue.

The above muscle experiment shows that fatigue is a relative fatigue. By this I mean that fatigue in the physiological sense does not denote an absolute state; it only means that a stimuli previously capable of eliciting a response is now no longer able to do so. On this account many of the experiments performed on the separate muscle gives us little knowledge of the fatigue seen in the living body. Take, for example, the well-known experiment of fatiguing a muscle to electrical stimuli and then causing it to contract through an effort of the will and again the reverse experiment of voluntarily fatiguing a finger in the ergograph and then causing it to contract by an electrical stimulus. When we, therefore, discuss fatigue as it occurs in life we must guard against considering each part in the complicated process of muscular movement by itself, and must rather look upon the whole process.

Let us now pass on to the muscle nerve preparation. We will first prove that the nerve is a peculiar tissue of the body in so much that it is practically non-fatiguable. To prove this we stimulate a nerve at one end and prevent the muscle from contracting by blocking the current between the stimulated end and the muscle with a polarising current in the opposite direction or by the application of cold. By employing a control experiment without such a block it is possible to show that when the muscle of the control no longer responds, the other muscle contracts on removal of the polarising current or the cold block. In all these experiments one must guard against "stimulation fatigue," *i.e.*, if the exciting electrodes be not moved, there will be a local fatigue developed at their point of application. Every tissue in the

body is subject to two chemical forces, one of assimilation and the other of dissimilation. Representing these forces by the symbols A and D, it will be seen that the fraction A/D is intimately connected with the question of fatigue. In an excised muscle each contraction causes a certain amount of dissimilation, and as there is no blood supply the numerator of the fraction A/D does not correspondingly increase, with the result that fatigue sets in rapidly. In the living body, however, muscular effort is always attended with a general rise in blood pressure and a local vasodilation. The numerator of the fraction A/D will, therefore, keep pace with the denominator D, and fatigue will only set in when these adaptive mechanisms are fatigued and can no longer supply the active tissue with food sufficient for its metabolism.

Now you may ask what has all this to do with the fact that a nerve cannot be fatigued. Apply the fraction A/D to the case of the nerve, and we then have to discover a metabolism for the nerve which prevents the quantity A decreasing. When Walter discovered the relation of nerve to fatigue he naturally jumped on the medullary sheath for an explanation. Here we have a thick, heavily-laden, fatty sheath, and, as far as a food store is concerned, an ideal structure for keeping up the quantity A. In common with all physiological studies, directly this was formulated, attempts were made to disprove the function of the medullary sheath in this respect, Brodie and Halliburton succeeding in the case of the splenic nerve of the pike. These observers showed that former experimenters had not guarded against stimulation fatigue, and that the sympathetic nervous system which is always in action could hardly owe its property of being non-fatiguable to the medullary sheath which it does not possess. On the other hand, it has been shown that the longest nerves in the body have the largest sheaths, so that we cannot altogether rob the medullary sheath of some nutritive function.

Now, it is universally granted that the nerve is a living tissue and does not act as a telephone wire; it, therefore, must have a metabolism; efforts to determine this have failed, no observer has yet succeeded in finding the characteristic product of metabolism CO_2 to be given off from a nerve fibre. The absence of fatigue in a nerve and the anomalous position it occupies as a metabolising tissue in the body go hand in hand, and when one of these processes is explained the other will probably follow as a corollary.

Having now stated the relation of the nerve to fatigue we can diminish the probable seats of fatigue in a nerve muscle preparation by one. I have already said that after the muscle will not respond as a result of stimulation of its nerve it will respond to direct stimulation. We have, therefore, to decide whether the nerve ending or intermediate substance is the seat of this fatigue. The evidence deciding in favour of the intermediate substance is not of a very direct nature. It is assumed that as the drugs curare and nicotine act first on the intermediate substance of a denervated bed muscle that this constitutes the weakest part of the chain and is first affected by fatigue. The same relation holds between adrenalin and the involuntary musculature of the body, and if we follow Elliott Smith we would regard the intermediate substance as homologous to that part of the autonomic system lying peripheral to the lateral chain of ganglion, *i.e.*, the post-ganglionic part.

Before proceeding to discuss the probable seat of fatigue in a typical segmental reflex of the cord I would like to say a few words on the various methods of fatiguing a muscle. In the laboratory the electrical stimulus has been used with most success, but fatigue can be induced by mechanical, thermal, and chemical stimuli. In employing the last two methods one wonders whether the muscle substance was not killed directly, the protoplasm of muscle being very susceptible to chemical and thermal changes of its environment. If a dying muscle be tested it will be found that after it is fatigued to chemical stimuli it will react to electrical stimuli, and that after being fatigued to these it will still respond to mechanical stimuli.

These experiments are not worth much, because we cannot compare the relative amounts of energy used in the method of excitation. Everyone here knows that in doing an experiment on a gastrocnemius it is frequently necessary to approximate the primary and secondary coil towards the end of the experiment, *i.e.*, to increase the exciting shock. In the above experiment one is given to understand that when the muscle absolutely refused to respond to electrical stimuli of any magnitude it would respond to moderate mechanical stimuli. The only way these results can be explained are by an extension or contradiction of Muller's Law of Specific Nerves, neither of which I am prepared to formulate.

As the contraction of a muscle is the same however excited, we have no method of discovering what really happens during the period of excitation; supposing we had fatigued the chemical nerve ending by prolonged chemical excitation, chemical stimuli of sufficient strength ought still to stimulate the other hypothetical nerve endings according to Muller's Law, and assuming the above experiment correct, how do we know that successive electrical stimuli are not exciting the chemical nerve endings, and so producing the visible contraction of the muscle. One gets further in the mire when one learns that muscular tissue is inexcitable by induction shocks, but only by single galvanic shocks. The ordinary stimulation of a muscle by induction shocks would, according to Schiff, be due to stimulation of nerve ending or intermediate substance. He gives no details of how this conclusion is arrived at; one can hardly imagine these results

derived from the nerveless ending of the sartorius or gracilis of a frog. According to the same observer fatigue induced by induction shocks can be overcome by galvanic shocks.

After an account of these experiments it must be apparent how difficult and dangerous it is to dogmatise on the inner nature of fatigue in muscle. By muscle I mean voluntary striated muscle; no doubt fatigue exists in semi-striated cardiac muscle and in the involuntary muscle of the intestine, but these tissues are so little capable of experiments on fatigue that one can form only hypotheses concerning the process of fatigue in them. Owing to the periods of diastole and systole being equal, fatigue in the human heart is not physiological. The depressor nerve in the rabbit and the part of the vagus representing this nerve in man seem a preventative mechanism against fatigue in the heart. An accessory mechanism against fatigue in the heart is seen if we compare the times for systole in a heart beating at different rates. Taking extremes, a heart beating 32 times a minute will take ·382 secs. for a systole, a heart beating four times that rate, *i.e.*, 128 times a minute, will take ·190 secs. for a systole, so that the total effect of increasing the heart beat four times is only to double the active metabolism of the heart. Expressed in other terms the diastolic time relations of the heart are the most disturbed with varying rate of heart beat. To those of us who have felt our hearts trying to break through our ribs this assurance of the absence of fatigue in cardiac muscle will come as a great relief.

There is no need to define a reflex action, and with the facts already at our disposal we can easily locate the seat of fatigue in the cord. The nerves show an absence of fatigue. After application of a stimulus to a definite point on the body the muscle can still be made to contract by excitation of its motor cell or nerve, even though the efferent part of the reflex does not occur as a result of surface stimulation. We have, therefore, to decide whether the motor nerve cell, or its synapses with the afferent path are fatigued. We know that the post root ganglion is not fatigued because, on moving the electrodes a short distance, stimulation causes a regular reflex movement of the limb or other part of body, showing that the ganglion is normal, as the nerve fibres supplying a square mm. of skin pass to the same ganglion, and this is the area within which electrodes need be moved to elicit a new reflex movement. It is true that one particular nerve cell in the ganglion may be fatigued, and I must admit that I can find no evidence to eliminate this possibility.

No one has, as far as I know, killed the animal after fatiguing a particular reflex and sought for Nissl's chromatolysis in the posterior root ganglion of the corresponding body segment. To those of us who have had to show Nissl's granules it would be hard to believe that the method in the best hands could show degeneration or fatigue in a single cell. To decide, then, whether the motor cell of the anterior horn or its synapses are fatigued we employ a dog whose cord has been cut in the upper dorsal region. If such a dog be held up by its fore legs, the hind limbs perform a mark time movement. If the foot of the animal be painfully stimulated with a pinprick, it flexes its foot at once, this flexor reflex absolutely inhibiting the former mark time one. This flexor reflex will also inhibit the scratch reflex obtained by gently stimulating the skin over the shoulders of the dog. If we fatigue this scratch reflex and then attempt to elicit this flexor reflex we are successful. Now the movements of flexion seen in the scratch reflex are exactly the same as those seen in the pure flexor reflex, so that although we have fatigued the reflex we have not fatigued the motor neurons capable of initiating the movement of flexion. We have, therefore, eliminated the motor neuron as the seat of fatigue in a typical segmental reflex and localised the fatigue in the synapses in the cord. I cannot see how to eliminate the peripheral sense organ or cells of posterior root ganglion in fatigue of a reflex action, for once fatigue has set in, stimulation peripheral to cord is ineffective where the electrodes be applied. The seat of fatigue in a reflex action is, therefore, certainly in the synapses of cord and probably in those of ganglion, a sense organ being, therefore, altogether on the afferent side.

If this subject were to receive rigid logical treatment it would be necessary to now pass on to a consideration of reflexes involving, in the first place, more than one segment of the cord; then to reflexes involving the co-operation of the medulla, pons, etc., until we finally reached the cerebral cortex itself. If this treatment of the subject would give us results which might be applied to fatigue as seen in man it might be persisted in ; on the other hand, if it is not going to enlighten us on fatigue as seen in man it need not be discussed.

Believing that general fatigue is but slightly related to changes in the lower parts of the brain, I pass on to a consideration of fatigue of the cerebral cortex.

It is a familiar experience that intellectual labour becomes impossible if maintained for too long a period. It is quite possible that in this fatigue the eyes play a great part; on the other hand, signs of fatigue in the eye cannot be obtained in many cases. If one has been at work some hours, and then obtains relief at a shooting gallery, one does not find any sign of fatigue in the eye. Again, cerebral fatigue proper lasts much longer than any retinal effect which can be produced experimentally. Although I have never experienced the sensation myself, I am told that such a thing as "second wind" does exist for the cerebrum. That is to say, if, after the period of fatigue

has set in, work be persisted in, a return to one's normal capacity occurs." It is, however, questionable whether cerebral exercise is being performed during this process of recovery; if it is not then this process of repair is no different to that found in any other tissue. Although the process of thought has never been shown to increase the needs of the brain as far as O_2 is concerned, we know that the nerve cells are very sensitive to want of O_2 and increase in CO_2, and coupling this fact with the dependent and incomplete vaso-motor control of the cranial cavity we would expect that in ordinary fatigue the cerebral hemispheres must play a large part, and that the part they play must occur early.

(To be continued.)

Notices.

Metropolitan Asylums Board.

INSTRUCTION IN FEVERS.

May Class, 1915.

A Course of Instruction in the Diagnosis and Treatment of Fevers will be held at each of the undermentioned Hospitals on the days and at the times stated below. N.B.—Attendance may be commenced during the second month of a course.

Eastern Hospital, Homerton Grove, Homerton, N.E. E. W. Goodall, M.D., Medical Superintendent. Monday and Thursday morning at 11, beginning 3rd May.

North-Eastern Hospital. St. Ann's Road, Tottenham, N. F. H. Thomson, M.B., Medical Superintendent. Monday and Thursday morning at 11, beginning 3rd May. (The stations nearest to the hospital are St. Ann's Road and West Green.)

North-Western Hospital, Lawn Road, Hampstead, N.W. J. MacCombie, M.D., Medical Superintendent, Tuesday and Friday at 2 p.m., beginning 4th May.

Western Hospital, Seagrave Road, Fulham, S.W. R. M. Bruce, M.R.C.S., Medical Superintendent. Tuesday and Friday at 2 p.m., beginning 11th May.

South-Western Hospital, Landor Road, Stockwell, S.W. F. Foord Caiger, M.D., Medical Superintendent. Tuesday and Friday at 2 p.m., beginning 4th May.

Grove Hospital, Tooting Grove, Tooting Graveney, S.W. J. E. Beggs, M.D., Medical Superintendent. Wednesday at 2.30 p.m., and Saturday morning at 11, beginning 5th May. (Nearest station, Balham; electric tram service 2, 4 and 8; motor omnibuses, services 66, 67 and 88.)

Park Hospital, Hither Green, Lewisham, S.E. T. F. Ricketts, M.D., Medical Superintendent. Tuesday and Friday at 11 a.m., beginning 4th May.

Brook Hospital, Shooters Hill, Woolwich, S.E. J. B. Byles, M.B., Medical Superintendent. Monday and Thursday at 2.15 p.m., beginning 3rd May. (Motor omnibuses from Blackheath Station (South Eastern and Chatham Railway) to the hospital.)

The succeeding Course will commence in October, 1915.

Students who desire to attend a course of instruction must, before attending at the hospital, bring between 11 a.m. and 4 p.m on any week-day (except Saturday), or send by post to the Clerk to the Metropolitan Asylums Board, Embankment, E.C. (1) authority from the Dean of the Medical School; (2) fee—£3 3s. for two months' course, or £4 4s. for three months' course. Cheques to be made payable to "The Metropolitan Asylums Board."

The student must definitely ascertain before taking out his course whether he requires a two or a three months' course. In the event of his taking out a three months' course, the extra £1 1s. will not be refunded to him. (3) full name and address, and name of Medical School. N.B.—The name must be in full, and must be distinctly written. (4) the names of at least two of the above hospitals, arranged in the order in which the student would prefer to attend, in case the classes at any of the hospitals should be already full.

By order,
T. DUNCOMBE MANN,
April, 1915. Clerk to the Board.

Pass List.

Conjoint Examination.

Examining Board in England by the Royal College of Physicians of London and the Royal College of Physicians of England.

At the first Professional Examination of the Conjoint Board held on March 23rd, 24th, 25th, and 26th, the following candidates were approved in the undermentioned subjects:—

Chemistry and Physics.

J. G. Barrie. J. E. H. Duckworth.
C. B, Dix. A. G. Ord.
J. H. Sullaiman.

Biology.

John Kendall. A. R. Neckles.
G. B. Kirkland. A. G. Ord.
S. Wolff.

Practical Pharmacy.

A. Alan Forty. N. E. Kendall.
J. P. Jones. A. G. M. Severn.
J. G. Stevens.

2nd Conjoint Examination.

Anatomy and Physiology.

H, D. Apergis. F. J. Harrington.
E. H, Bryant. G. R. Hubbard.

Royal College of Surgeons.

At the Preliminary Science Examination for the Licence in Dental Surgery, held on March 23rd–26th, the following candidates were approved in the undermentioned subjects :—

Chemistry and Physics.

C. D. M. Dorward. E. W. Jarvis.
I. J. Gardiner, E. H. Richards.
D. K. Gaskill. C. H. Sterne-Horwitz.

Physics.

L. F. Fouraker.

Chemistry.

F. G. P. Flanders. Stanley Godsill.

University of London.

Second Examination for Medical Degress, Part II.

March, 1915.

Anatomy, Physiology and Pharmacology.

C. W. W. Baxter. E. C. Hinde.
Eric Biddle. V. R. Hirsh.
D. H. M. Galbraith. F. R. Leblanc.
A. F. G. Guinness. E. S. Phillips.
T. L. Heath. H. N. Pritchett.

Second Examination for Medical Degrees, Part I.

March, 1915.

W. H. Grace. W. H. Simmons.
R. S. Ralph. R. W. Warwick.

University of Durham.

Second Examination for the Degree of Bachelor of Medicine.

March, 1915.

Anatomy and Physiology. Honours 2nd Class.

J. A. Berry.

First Examination for the Degree of Bachelor of Medicine.

March, 1915.

L. Lavine.

Books recently added to the Wills Library.

By Purchase.

Hutchison's Diseases of Children, 1913.
Cunningham's Practical Anatomy, vol. ii., 1914.
Norris's Gonorrhœa in Women, 1913.
Luff and Candy's Manual of Chemistry, 1915.
May and Worth's Diseases of the Eye, 1914.
Bainbridge and Menzies' Physiology, 1914.
Latham and Torrens' Medical Diagnosis, 1915.
Marshall's Syphilology, 1914.
Underwood's Aids to Dental Anatomy, 1914.
British Pharmacopœia, 1914.
Howard's The Practice of Surgery, 1914.
Beattie and Dickson's General Pathology, 1908.
Monyihan's Abdominal Operations, 2 vols., 1914.
Barcroft's Respiratory Functions of the Blood, 1914.
Fraser's Anatomy of the Human Skeleton, 1914.

Presented.

Buchanan's Handbook of Surgery, 1906. By an Old Guy's Man.
Pearson's Modern Surgical Technique, 1912. By an Old Guy's Man.
Gruner's Biology of Blood Cells, 1914. By Dr. G. W. Nicholson.
Murray's Edward Alanson and his times, 1914. By Mr. R. W. Murray, F.R.C.S.
Keefer's Military Hygiene, 1913. By Dr. H. C. Cameron.
Proceedings of the Royal Society of Medicine, vol. 8, 1914. By Dr. J. Batteson.
Capt. J. Furse McMillan, R.A.M.C. Asiatic Cholera, 1914. By the Author.
Dr. Reginald Hayes. The Treatment of Syphilis by Aachen's Method, 1914. By the Author.
Dr. W. Hale White. Materia Medica, Pharmacy, Pharmacology, and Therapeutics, 1914. By the Author.
Report on Odontomes, 1914. By the British Dental Association.
Journal of Physiology (as published). By Dr. A. F. Hertz.
Archives of the Roentgen Ray (as published). By Dr. A. F. Hertz.
Practitioner (as published). By Dr. A. F. Hertz.

Births.

TICEHURST.—On March 29th, at 35, Pevensey Road, St. Leonard's-on-Sea, the wife of Norman F. Ticehurst, M.B., F.R.C.S. Eng., of a son.

BURNEY.—On April 4th, at Lancaster Place, South Hampstead, London, the wife of Captain W. H. Skardon Burney, R.A.M.C., Indian Expeditionary Force, of a daughter.

DISMORR. — On April 4th, at Milton House, Gravesend, the wife of Cecil James Stewart Dismorr, M.R.C.S., L.R.C.P., of a son.

Marriage.

WILLIAMS—CHADWICK.—On the 14th April, 1915, at St. George's Church, Stockport, by the Rev. John H. Thorpe, B.D., Owen E. Williams, M.R.C.S., L.R.C.P., son of Owen Williams, Tre Morfa, Tal-y-Cafn, to Beatrice Maud, youngest daughter of the late Enoch Chadwick, of Tunstall, Staffs.

W. E. T.

GUY'S HOSPITAL GAZETTE.

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Passim.

THEIR Majesties the King and Queen paid an informal visit to the Hospital on Saturday, May 1st. They arrived at 3.30 p.m., and were conducted to the Officers' Section, where their Majesties made a complete round of the ward and chatted to each wounded officer in turn. Our six Canadian officers were praised for their good work. Everyone who had the honour to be present was surprised at the wonderfully accurate knowledge which the King possessed of the routine of ward work, and of those special branches of surgery for which Guy's surgeons have become famous. Their Majesties were very much amused by some of the notices over the cubicles, one of which was labelled "The Abode of Love," and another "Too ill to be nursed." The silent rubber flooring was also admired. At first their Majesties refused to take tea, but when the Queen saw the tea-trays prepared on the table, Her Majesty changed her mind, and the King and Queen thoroughly enjoyed a cup of tea. Before departing, their Majesties signed the Visitors' Book, and the King congratulated Sister on the careful arrangements made for the comfort and happiness of the wounded heroes.

On Monday the ward was decorated with daffodils and narcissi, graciously sent by their Majesties. On Tuesday the Matron received a letter and a parcel of shirts for a wounded Canadian Officer, who was so overcome that tears came to his eyes when this kind and thoughtful gift was handed to him.

"The Queen was much interested in the case of the Canadian Officer wounded so badly in the back, and she is sending him some specially made shirts from a pattern which has been found useful in these kind of cases. Please give them to the Officer from Her Majesty with her best wishes for his recovery. The Queen also desires me to say how much interested their Majesties were in their visit to Guy's last Saturday."

Yours sincerely,
EVA DUGDALE,
Lady-in-Waiting.

On behalf of the officers whose suffering has been made lighter, and those in the Hospital who are now spurred to greater efforts, we wish to thank Their Majesties for their continued interest in our Hospital. Their noble examples of devotion to duty, charity, and self-sacrifice which they give every day are an inspiration to us all.

AT their last meeting the Governors passed a vote of thanks to the Queensland Government for the magnificent present the Hospital has received from them through the Agent-General. You will appreciate the magnitude of the gift when you know that it included 50 quarters of beef, 50 carcases of mutton, 8 bags of flour, 5 hundredweight of granulated sugar, 240 pounds of cheese, 4 cases of unsweetened condensed milk, 4 cases of sweetened condensed milk, 8 sides of smoked bacon, 16 sides

of green bacon, 224 pounds of butter, 192 pounds of corned beef, and 192 pounds of roast beef.

Sir Alfred Fripp will resume his hospital duties very shortly, and when Sir Alfred returns Mr. Turner will place his services at the disposal of the War Office. Mr. Trethowan has been elected temporary Assistant Surgeon during Mr. Turner's absence, and Mr. Gardiner has kindly consented to continue his attendance at Surgical Out-Patients on Mondays.

The next meeting of the Guy's Hospital Ladies' Association will take place on Tuesday, May 11th, at 3 p.m.

We are extremely sorry to hear that Second Lieutenant Hugh Bertrand Neely was killed on Sunday, April 25th, during the fighting near Ypres.

Born in 1888, he was the second son of Mr. William Neely, of Bromley. Educated at Lancing, H. B. Neely entered Guy's Hospital Dental School in 1908, having passed the London Matriculation in January, 1905, and qualified L.D.S. in 1912. In addition to the ordinary hospital appointments he was Assistant Demonstrator of Metallurgy and Assistant Dental House-Surgeon.

At the outbreak of the war Neely rejoined his old corps, the Artists, and shortly afterwards was gazetted to the Suffolk Regiment.

Messrs. Wills, Danby and Symonds left the Hospital at the end of April; we wish them every success in their future careers.

The new Residents took up their duties at the beginning of May; Messrs. C. Dean (Dr. Hale White's H.P.); L. Muir Smith (Dr. Fawcett's H.P.); R. W. P. Jackson (Dr. Beddard's H.P.); C. Lambrinudi (Sir A. Fripp's H.S.), and P. D. Scott (Mr. Steward's H.S.). W. E. Tanner (Sir A. Lane's H.S.) has been elected President, and R. Sells (Ophthalmic H.S.) Vice-President of the Residents for the ensuing three months.

Mr. G. A. Turner, son of the late Sir George Turner. has very kindly sent us a copy of the notice which appeared in the *South African Medical Journal* concerning the late Dr. E. T. E. Hamilton, whose obituary appeared in our last issue. We feel sure all Guy's men will appreciate this tribute to the memory of a brilliant man.

A Lecture will be given by Dr. Louis Sambon on The Preventative Measures to be adopted against Diseases likely to occur during the War, at Claridge's Hotel, on Tuesday, May 11th, at 3 o'clock. Tickets, which are 4/- each (including Tea), may be obtained from The Belgian Soldiers' Fund, 19, James Street, Oxford Street, W. The proceeds of the Lecture will be devoted to the Belgian Soldiers' Fund.

In the recent Final Conjoint Examination 15 men passed in Medicine, and two were referred; 14 men passed in Surgery, and five were referred; seven men pased in Midwifery, and two were referred. These results are very satisfactory.

Mr. H. G. Grattan informs us that there is a great demaud for the 1909 edition of "Gray's Anatomy." Will any men who have second-hand copies for disposal communicate with Mr. Grattan?

Papers by Guy's Men.

Handley (W. Sampson), M.S. Lond., F.R.C.S. Eng.: Abstract of the Hunterian Lecture on Ileus Duplex (Inflammatory Enterocolic Ileus).—*Lancet*, May 1, 1915.

E. G. Schlesinger, M.B., B.S., F.R.C.S., and others Radioscopy with the 3rd French Army.—*Ibid.*

Charles Higgens, F.R.C.S.: The Scotoma of Migraine.—*Ibid.*

Col. F. F. Burghard, M.D., M.S., F.R.C.S.: Memorandum on the treatment of the bacterial infections of projectile wounds.—*Ibid.*, April 24, 1915.

Trevor B. Heaton, M.B., B.Ch., M.R.C.P.: On gastric analysis.—*Brit. Med. Jour.*, April 24, 1915.

Maj. A. H. Tubby, R.A.M.C.(T.), M.S., F.R.C.S.: A method of treating compound fractures of the femur due to projectiles.—*Ibid.*

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Obituary.

Dr. E. T. E. HAMILTON.

DEATH has taken heavy toll from our ranks in Johannesburg of recent times; Duirs, the doyen of the profession here, prematurely aged from strenuous work in the pioneer days; Carlyon, Johnson Brown, and Grace, all men in the prime of life; Mitchell, whose grim fight against overwhelming odds is an example to every victim of the ubiquitous bacillus; Stuart, Stanley, and others have all passed over within a very brief period; and now we have to mourn the passing of "Neddy" Hamilton, and mourn indeed we must for never shall we look upon his like again.

Of the circumstances of his tragic end little need be said here. One of the first volunteers on the outbreak of hostilities, he left Johannesburg with the Transvaal Horse Artillery at the initiation of the campaign in German South-West Africa, and since then with the exception of a brief furlough at Christmas time when he paid a very welcome visit to Johannesburg, he had been on active service with the troops engaged in quelling the rebellion and in German South-West Africa; latterly he had been in medical charge at Swakopmund, and it was from there that he returned to his home invalided at the end of February, suffering from a sub-acute intestinal complaint and from mental depression brought on no doubt by overwork and weariness of the flesh, and out of all proportion to the severity of his physical complaint. Without doubt it may be said that this mental depression took the form of a morbid dread of losing his reason, and in an acute exacerbation he took his life, preferring death to an imagined alternative of a life deprived of charm and usefulness.

In this Journal, conceived, initiated, and in its infancy nurtured by him, it is unnecessary to enter into a recital of his brilliant academic career in London and at Guy's, or even to accentuate the fact, so well known to most of us, that with this intellectual brilliance he combined (and it is a most unusual combination) every attribute of the ideal practitioner.

To know Hamilton was a privilege; to be on terms of intimate friendship with him was a rare delight; as a companion he was unsurpassable, and his participation in the numerous informal gatherings in hospital, club, and home, which form perhaps the most pleasant feature of our medical life here, ever ensured for the time the banishment of dull care; his was the vital and stimulating influence that gave to such meetings their greatest value to us all; his the finest wit and keenest sense of humour; his the readiness and ability to turn a discussion, verging perhaps on the acrimonious into smooth channels, and pilot it to safe anchorage in a sound decision. His influence was great, greater by far than he ever in his modesty imagined; and was always exercised in the upholding of the best traditions of the profession he loved, and of which he was indeed a worthy and brilliant exponent. He had the faculty of inspiring others to an unusual degree; in debate or discussion, to keep pace with him demanded the intellectual best of every man of us present; and with his wide and sympathic knowledge of humanity and his extended experience, his well-considered judgment and advice were always freely and generously given to his colleagues and were rarely at fault.

Apart from his loss to the profession in Johannesburg and South Africa for these qualities, briefly and inadequately enumerated, it remains to say a few words from the aspect of one of those numerous friends in the profession who knew and loved him: he was indeed a true, generous, and loyal friend, with the happiest disposition ever known; in sickness or sorrow his sympathic and cheery presence was always the best antidote; in times of pleasant relaxation his spontaneous gaiety and lightness of heart made him the very life and soul of every party out for enjoyment. It is difficult indeed to realise that he has gone, and the manner of his going; and it means to many of us a very different Johannesburg for the rest of our time here.

To his widow we respectfully and sorrowfully offer our sincerest sympathy and condolences.

Farewell! Farewell!! Neddy Hamilton, of happy memory! S. J. S.

Killed! Second Lieut. H. B. NEELY,
3rd Batt. Suffolk Regiment.

"Dead on the field of honour!" How grand! How terrible, and—how sad! Those of us who have personal recollections of H. B. Neely will read of his death with acute regret, for a finer man, a cleaner sportsman, never entered the hospital.

From his earliest days at Guy's, when he came as a pupil in Dental Mechanics in October, 1908, to the time he qualified in November, 1912, he was a tower of strength to the Dental side, mentally and physically. In addition to his ordinary hospital appointments, he was Assistant Demonstrator of Dental Metallurgy from January to March, 1911, and Assistant Dental House Surgeon from July to September, 1912.

At sports he was in his element, and won his full Hospital and United Hospital colours for football.

After taking his degree he passed into private practice, filling two or three posts as assistant, for a short time, and then, setting up at Southampton. Here he was very successful until war broke out, when he immediately closed his practice, like the sportsman he was, and rejoined his old volunteer regiment, "The Artists." Later he received his commision as Second Lieutenant in the 3rd Battalion of the Suffolk Regiment, and was sent on active service to France.

In the heavy fighting which took place around Yprès about the end of April, he was one of the many officers who fell in action—brave men who gave

their lives cheerfully and willingly for their country. We men of Guy's can realise what a loss he must have been to his men, for he was always a man who thought for others before himself.

He was a man full of life, extremely versatile in his accomplishments, clever, and witty. No one of the United Hospital A.F.C. tour team of 1911-1912 will forget his "Los Billetos" trick *en route* for Barcelona, or his rendering of "Our Bazaar" at the Vice-Consul's house, clad in football clothes, and wearing a pair of black trousers round his neck as a cassock, a sheet as a surplice, and a pair of red footer stockings as a stole. Will any man who took part in the mock trial, which took place in the Pupils' Laboratory some time in 1909, forget this huge joke which owed its inception and success to poor H. B. and, I believe, his brother Guy. Indeed, H. B., you were a man to be loved and appreciated by men. Always, in the future, Guy's men who knew you will raise their glasses in a silent toast to the memory of Second Lieutenant H. B. Neely of the 3rd Suffolk Regiment, and of Guy's.

We take this opportunity on the behalf of those who knew and liked you to offer our united sympathy to Mr. and Mrs. Neely and family on their great loss.

P. S. H.

Appointments.

Naval.

To be temporary Surgeon, R.N.:—H. L. Peregrine.

Surg. R. A. Rankine, R.N., to the *Pembroke*.

Surg. K. H. Hole, R.N., to the *Thames*.

Royal Army Medical Corps.

Lieut.-Col. A. W. Sheen, R.A.M.C. (T.), M.D., M.S., F.R.C.S, O.C. Welsh Hospital. Netley, Southampton.

Lieut. F. E. A. Carr, R.A.M.C., O.C. Station Hospital, Calial, India.

W. R. Ransford (of Rangoon), 2nd Lieut. Indian Army Reserve of Officers, to be attached as 2nd Lieut., 1st Batt., 10th Gurkha Rifles.

D. B. Morrish, Artists Rifles (28th County of London).

H. T. G. Berncastle to be 2nd Lieut., Bedfordshire Regiment.

C. P. Symonds, P. W. L Camps, Robert Denman, E. R. Stone, Edgar Ashby. All to be temporary Lieutenants.

2nd London (City of London) General Hospital.—Capt. Sir W. Arbuthnot Lane, Bart., is seconded.

Attached to other than Medical Units.

To be Lieutenant:—Sidney Hughes.

A. G. Forrest, Private in H Company, Pretoria Regiment (German South-West Africa).

The Nature and Seat of Fatigue.

A Paper read before the Guy's Hospital Physiological Society by J. JOFFÉ.

(Continued)

In an ordinary voluntary movement, as performed by the extensor indicis muscle in an ergograph, the muscle will contract to electric stimuli when voluntary movement is no longer possible; if the motor cortex is not fatigued, what is? The action of psychic stimuli on fatigue shows well the relation of the hemispheres to fatigue; there is no doubt that the present agitation for military bands is founded on solid experience and is at any rate a safer "anti-fatigue" measure than the chewing of coca leaves, in which the American Indians indulge for similar reasons. One might endeavour to explain the beneficial effects of the band by the fact that the men then march at an optimum pace, set by the band; this optimum pace being that at which the muscle works with the greatest efficiency. That this view does not explain everything is shown by the following considerations. In the first place, there could not exist the same optimum for all men, although by practise this optimum may be rendered a fixed quantity for all men; in the second place, the rhythm of music does not influence in one direction or the other the onset of fatigue.

Most of us have been recruits at one time, and can vouch for this effect of cerebral effect on fatigue. Though one is ready to drop on one's first long march, psychic stimuli in the way of not allowing other men to see one's weakness keep one going. With sufficient will power, then, one gets over this primary period of fatigue; no doubt other factors, such as second wind (should dyspnœa be present), lend a helping hand, more particularly in the later stages. Death from fatigue is comparatively rare: there are the classical cases of the Marathon runners who fell dead at the end of the race; did they die of fatigue of the heart or respiratory centre? The cerebral hemispheres, therefore, play an important and early part in the fatigue of everyday life.

I pass now to a consideration of fatigue in the various sense organs. A priori we would expect that all sensory nerve endings are capable of being fatigued. The sensory nerve endings comprise those of pain, touch, temperature (hot and cold spots), tactile discrimination.

Most of us find it difficult to believe that the nerve ending stimulated by pain is capable of fatigue, but we do fall asleep with a raging toothache and awake with it the next morning. It would be a great coincidence if the cause of the pain were to stop during

the time of sleep. What is more probable is that the cerebral station of the pain fibres are first fatigued and that waking represents the return of these cells to the normal, when they can appreciate the message brought by the pain fibre. I can find no evidence where anyone has applied a given stimulus to a pain spot so often that in order to provoke a sensation he has had to increase threshold stimulus.

It is obvious that this property of fatigue coming on slowly in the pain nerve ending is a preventative mechanism. If these endings were soon fatigued, the patient with a bad tooth would spend weeks deciding whether it ought to be seen to or not, his frame of mind depending on the presence or absence of fatigue in the nerve ending. In the end, through neglect, his tooth would have to be extracted. As it is, the pain lasts sufficiently long to make up his mind at once with regard to the tooth. Since these sensory nerve endings determine the reaction of the organism to the stimuli of the external world, the organism would be in a bad position if these endings soon became fatigued.

The touch spots resemble the pain spots in their relation to fatigue and for similar reasons. The only experience I have had where my touch spots were fatigued was once where I held a coin for so long that I finally dropped it without knowing. This is nothing like a proof that these were fatigued, but it is likely that they were ultimately at fault, because the muscular work performed was too slight to bring on fatigue. Of course other elements may have entered, such as muscle sense.

One's experiences of changes in the temperature is sufficient to show how unaffected the hot and cold spots are by fatigue.

Having said something about the skin in relation to fatigue, I ought to consider fatigue in the eye, ear, nose, and gustatory apparatus. These are, however, very special subjects and need more time than I can give. The great point is that all these sense organs show fatigue, and we have to decide whether the nerve endings in the retina, those in the hair cells of the cochlea and others are responsible for this fatigue or whether the central connections are first fatigued. If one considers that besides the rods and cones there are three layers of nerve cells and two lots of synapses in the retina and the central connections of the optic tract, one hesitates at once to localise fatigue of the retina, and the same is true for the other four primary senses. A good deal of fatigue seen in the eye is purely muscular, but true retinal fatigue does exist, as was shown by Burch, who shone lights of different colours into the eye, showing how the retina could be fatigued to different colours. In this experiment there would be no muscular effect on the part of the patient. The experiment does not, however, give any indication as to the seat of the fatigue.

All functions carried out by the intact organism are an expression of the metabolism occurring therein. Fatigue in any of these functions is, therefore, primarily a result of a faulty or insufficient metabolism. To study the causes of fatigue is, therefore, to study this metabolism.

Metabolism means the intake of O_2 and output of CO_2. Excessive muscular effort is an exaggeration of these processes. In the absence of sufficient O_2, lactic acid is formed and not combusted to CO_2 and OH_2. Therefore the acid accumulates and has been held responsible for the accompanying fatigue. Some have gone so far as to say that the steady accumulation of this substance is the agent that brings on sleep. If lactic acid alone were the cause of fatigue it ought to be possible to produce fatigue in an animal by injecting this substance into the animal. Such injection does produce a drowsy state in the animal after other effects, such as rise in blood pressure and rate of respiration have been produced. The animal, therefore, goes through a similar train of phenomena, as does a man doing hard muscular work.

On the other hand, fatigue is often present when no lactic acid can be demonstrated. In muscular exercise that lasts for some time it is impossible to show the rise in lactic acid in the urine and blood that is found after short forced muscular exercise. Now, a man who has been walking for 24 hours is doubtlessly a subject to fatigue, and yet we can detect no sign of lactic acid. Lactic acid, therefore, though a factor in fatigue brought on by dyspnœic exercise will not explain all forms of fatigue.

Fatigue in a nerve cell shows definite histological changes. Now the reaction of the tissues to stains must ultimately depend on their chemical constitution. We must, therefore, assume that the fatigue in a nerve cell either causes one substance to disappear—the substance which attaches itself to methylene blue—or in the production of a third substance which interferes with the staining reaction. Beyond that we cannot say more.

The relation of fatigue to metabolism can be shown directly by experiment. If we ligature the sciatic artery of one leg of a frog and then stimulate the two gastrocnemii, we find that fatigue sets in on the ligatured side before it does on the more normal side. The importance of this experiment, when realised, leads to increasing the calorific allowance of the soldier by 1,000 cals. per day, with the result that fewer men dropped out on long marches. The increased calorific allowance that the Japanese received as compared with the Russian was probably a large factor in determining the victorious side.

Temperature also exercises an effect on the rate of onset of fatigue. If we consider the matter from a purely physical point of view, we can understand that a high temperature is to be avoided if fatigue is feared. Increase of temperature means increase in the rate of

chemical action, that is, more food stuff is metabolised, *i.e.*, fatigue will take place earlier. I do not say that this explains the injurious effects of temperature on fatigue, the matter is complicated by the very complex mechanism the mammal possesses of regulating his temperature.

I have already said that the chewing of coca leaves was a measure adopted by American Indians to prevent the onset of fatigue. Can we explain how this drug produces this effect? Cocaine is, in the first place, a general protoplasmic position; it may, therefore, act by diminishing the total metabolism of the body, and, therefore, delay the onset of fatigue. Cocaine, in the second place, paralyses the sensory nerve endings, so that, perhaps, fatigue is really present in a minor form, but does not reach consciousness. Remembering these two actions of cocaine and the fact that in larger doses it paralyses motor nerves, we see that we have by no means an ideal "anti-fatigue" measure in this drug. To prevent fatigue we therefore act on two principles :—

1. Cerebral or psychic stimulation.

2. A plentiful supply of food and consideration in hygienic conditions such as temperature.

Euphemia Up-to-date.

IT is never an easy matter to own to defeat at all, much less to break the news in graceful and encouraging phrases; this becomes all the more difficult when the recipients, instead of being a sorrowing and sympathetic nation, consist of a sceptical chief and a group of delighted subordinates. A careful study of the methods of our more emotional journals may, therefore, repay the harassed resident.

Everyone must remember some red-letter day on which he assisted at the administration of salvarsan, how the needle refused to be billeted in its proper quarters, how the officer commanding the sphygmomanometer forgot to reduce pressure at the right moment, how the N.C.O. (afterwards reduced) controlling the stop-cock was asleep at his post, and how a large amount of fluid eventually found its way on to the floor in the general chaos.

In times of peace one was reduced to bitter comments on the decadence in the size of veins and intelligence of assistants. Nowadays there is more hope, thus :—

CAPTURE OF HILL 606.
(Anyhow, we did get some in).
HEAVY WEATHER PREVENTS COMPLETE SUCCESS.
(Nasty crossing that, last night).
MYSTERY OF LOST RESERVES.
(Afterwards cleared up by the Junior Pro.).

Remarks by Eye-witness are better omitted as being somewhat bald and uninspired.

To take another case, let us suppose that that pre-systolic bruit *was* only the ward maid after all. Everyone knows the puzzled expression on the physician's face as he remarks, "Well, y'know, of course, there *may* have been one when you listened to it, these things change so, but I can't hear anything now; by the way, did you notice that she hasn't got any knee-jerks ?"

Of course, you hadn't, and there you were, a born fool, with sister positively purring with delight because an earlier tentative advance of hers on the subject of the exudative diathesis had been heavily repulsed by a short discourse on the advantages of head-washing for infants. At present the matter is simple :—

RE-ADJUSTMENT OF POSITION.

"Owing to unforeseen circumstances (always poking his nose in when he isn't expected; the Registrar was going over the case to-morrow) and the lack of support from our Allies (shan't call her an Ally again; rotten sort of smile), we have been compelled to make a slight alteration in our line of attack. Far from being a reverse, this alteration will prove beneficial in many ways (treatment may do some good now, for instance), and startling events may be looked for with confidence in the near future. (Vacancy for one competent H.-P. most probably)."

Anyhow, it sounds better than saying, "Er—knee-jerks? Er—I thought they were a bit sluggish, sir."

Just one more little point. If Surgeon N—ck did spot you that evening, the prognosis is hopeless. Euphemisms on a new-found desire to wrest the inner secrets of bedmaking and infant feeding are useless and should not be exhibited. Uncensored reports that would make a Wolff's Agency reporter gnash his teeth in envy will spread unchecked and irresistible, For what Miss Grundy is to the Borough—. Aye, and more also.

H. B. F.

Change of Address.

C. H. Stainer, 22, Twyford Avenue, W. Acton, from Middelburg, Transvaal.

Lieut. J. L. Perceval, R.A.M.C. (S.R.), 59th Field Ambulance, Sling Plantation, Bulford, Wilts.

H. T. G. Berncastle, 3rd Batt., Bedfordshire Regt., Felixstowe.

Lieut. A. Seabrooke, R.A.M.C., Rawal Pindi, British General Hospital, Boulogne Base.

(The Editor will be very glad to receive a post card with notes of any change of address.)

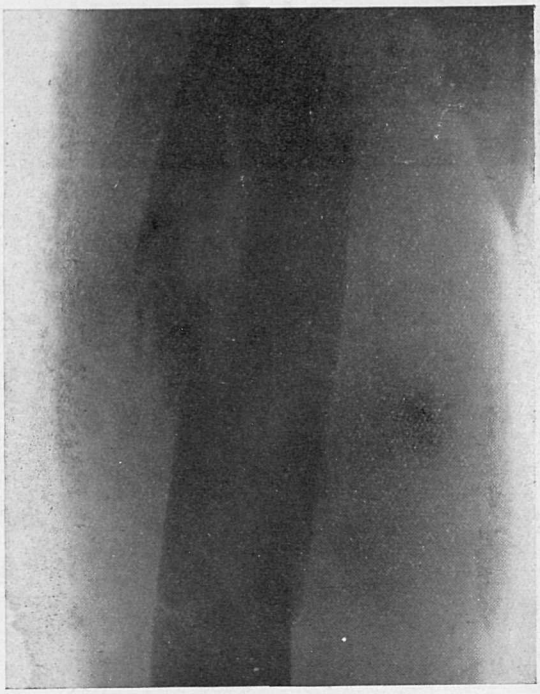


FIG. 1.

FIG. 2.

FIG. 3.

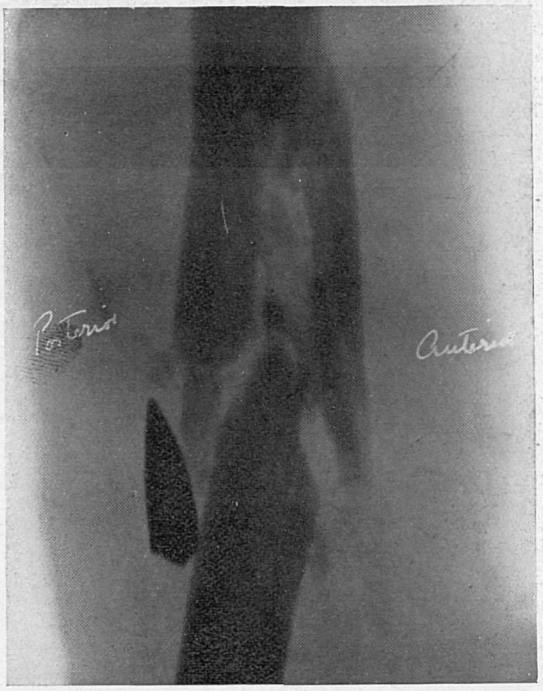


FIG. 4.

Skiagrams illustrating Mr. Charters J. Symonds' Clinical

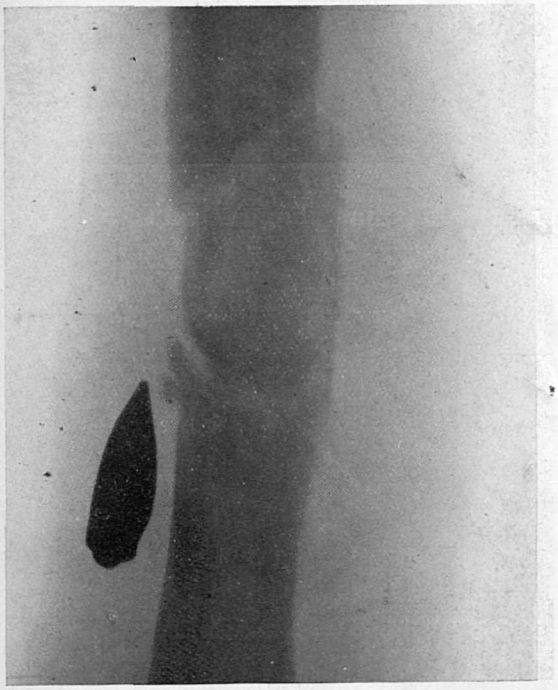


FIG. 5.

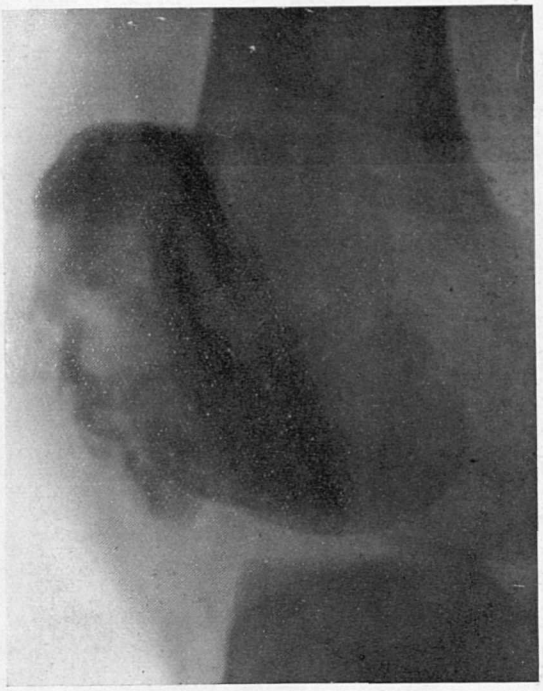


FIG. 6.

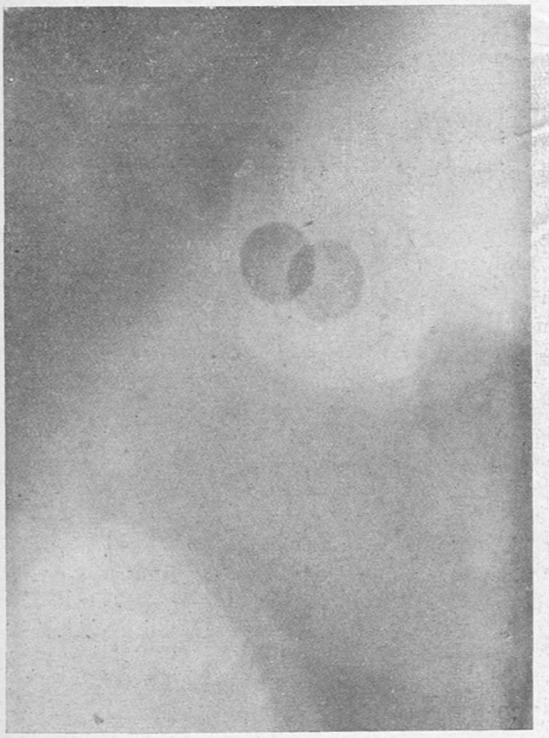


FIG. 7.

FIG. 8.

Gunshot Wounds and their Treatment.

CLINICAL LECTURE
BY
CHARTERS J. SYMONDS, M.S., F.R.C.S.,
on February 10th, 1915.

GENTLEMEN,—It is difficult, in a clinical lecture at this time, to keep away from war topics. I planned out a different lecture altogether for to-day, but I thought I would utilise the occasion to bring before you some interesting examples which have occurred within my own experience during the last few months of gunshot injuries.

In this war we have a great variety of wounds to deal with. It is very remarkable, when you think of it, that we are back almost to the days of the bow-and-arrow, for airmen are sending out solid steel arrows, and only yesterday an officer from the front told me they had for sport been using the bow and arrow, so close were the enemy trenches. Again, we are using the hand grenade of the Peninsula War. Moreover, before this war began I do not suppose anybody would have thought the rifle, capable of killing at a mile or more, would have been commonly used at a range of only 50 or 100 yards. For that reason the injuries differ considerably from those of the South African War, where the range was mostly 800 to 1,000 yards. Therefore, it has been rather difficult to exclude the possibility that explosive bullets have been used. I shall show you a most interesting case, and some radiograms of it, which made me think at first that this man had been hit by an explosive bullet.

I have not myself, nor have I met anyone in London, who has seen a recent bayonet wound. One would think there must have been such; if so, they do not appear to have come over here, or when inflicted they must have proved uniformly fatal. There is no doubt our men have inflicted bayonet wounds, though less frequently than has appeared from the newspaper reports. As far as one can judge, nobody likes to stand up against a bayonet charge; there is something about it which makes a man inclined to run away.

There have been several cases of comminuted fracture of the humerus without suppuration. The soldier I bring before you is a Grenadier, aged 20, who shows three wounds. The bullet entered at the back of the arm, shattered the bone, made its exit in front, and then lodged in the forearm over the radius. At the moment his bayonet had pinned an enemy to the ground, and the position explains the course of the missile. Notice the small scar of the wound of entrance and the slightly larger at the point of exit in the arm.

The first skiagram (Fig. 1) shows how the bone was broken into several fragments, the overlapping of some of these pieces, but, on the whole, a satisfactory alignment. The position of the conical bullet is shown in the second (Fig. 2). The bullet must have spent most of its force and been fired at long range. He shows you this bullet gilded, as you see, and worn upon his watch chain. The apex is little altered, but you will observe the indentation on the side from contact with the bone.

Unfortunately the musculo-spiral nerve was injured either by the bullet or the fragments, and you will notice that the wrist is dropped from paralysis of the muscles. After some three months I thought it wise to expose the nerve. It was firmly adherent to the bone and buried between the fragments, though its continuity was not broken. Still, it was so much injured that a portion was resected and the ends united by fine silk, and a piece of animal membrane wrapped round the site of operation. Primary union resulted, and there is every prospect that under electricity and massage he will regain power in a year's time. Meanwhile, being an active man, proud of his regiment, he will return for light duty and drill others for active service.

Here is another skiagram (Fig. 3) of a fracture of the humerus by a bullet. The bone is a good deal splintered, and the pieces overlap. The dark specks represent portions of the nickel casing and of the leaden core. This is rather a severe injury, and probably the shot was fired at fairly close range. The man recovered rapidly and required a splint for only two weeks.

This next example illustrates two points—a fracture of the humerus, very much split and slightly impacted, and, lying beside it, the typical pointed bullet of the period. The lateral view shows much separation, and, perhaps, you would not expect a rapid or sound union (Fig. 4). But the other aspect (Fig. 5) shows the position of the bones to be satisfactory. He carried his arm in a splint after coming to us for only a week. The bullet was easily removed, and he went out with a useful arm. Notice how well the bullet retained its shape.

To show how these bullets will traverse bones without causing any very great trouble, look at this case of patella injury. This man was admitted early in October with a very small punctured wound on the outer side of his knee, and with some effusion into the joint. The patella was very tender, and one thought the bullet had passed through without injury to the patella. Therefore I was much surprised when the skiagram (Fig. 6) showed how seriously the patella was broken. It is, you see, comminuted on the outer side. The effusion subsided, the patella healed, and he went out with a good moveable knee in three weeks. Here, again, the bullet was probably fired at long range.

Those who are acquainted with the South African War, and are able to compare the effects of the bullets in that campaign and this, tell us that the present bullet inflicts much more serious injuries than did the old Mauser bullet. Sir Anthony Bowlby remembers having seen the patella tunnelled without being split six times by Mauser bullets, but he has not seen a similar effect happen in this present war. And our conical bullet has more serious results than the old Lee-Metford; we may, perhaps, cry quits as to the relative severity of the injuries. So a bullet may enter the knee-joint, may break the patella, and yet a very good recovery may ensue and quickly.

The other kind of bullet we get is from the shrapnel shell. This is a steel case filled with round leaden bullets. We have seen a good many of these injuries, and one is struck by the simple character of the wounds which they produce. Here is a very good example (Fig. 7) of a shrapnel bullet lying just above the neck of the femur. The wound had healed and the man was comfortable; it was easy to remove, as one could cut down inside the line of the tensor fasciæ femoris. Some of the smaller bullets and fragments are best left. For instance, fragments of bullets among the muscles of the thigh may not cause any pain or impairment of movement.

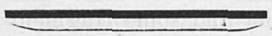
Recently a young fellow came in with a small wound from a piece of shell on the side of his nose. It had entered below the inner canthus on the left side, and had caused transient epistaxis. As there were no symptoms, or nasal trouble, the fragment was left.

I now want to turn to the cases which are septic. The striking thing about all the cases of suppurating bone injury, as well as those in soft tissue, was the presence of sepsis; so septic that they were positively offensive; and yet the patients were not ill; they had not got septicæmia. I speak with hesitation, because my experience is limited, but I have not seen a case which had general septicæmia, or which had pyæmia, despite the severity of the sepsis in the wounds. And if you read Sir Anthony Bowlby's article, which I strongly recommend you to do, you will not only get some conception of what is taking place at the front, but you will notice he says he has not seen a single case of septicæmia nor of pyæmia, though he is constantly visiting all the clearing hospitals up and down forty miles of our front. What that absence is due to I will presently suggest. Take the first case I was asked to handle. And here I have the advantage of bringing to this period of our time the experience I had in 1873-4, and from then to 1880, when we had any amount of septic infection in this hospital. In amputations, septicæmia and pyæmia were not uncommon, and erysipelas was rife. And so, when this man came under my care, it brought back those old days at once, and one felt ready to deal with it. One had not been narrowed—if I may use that term—by a pure training in aseptic surgery, and so one was able to bring one's old experience forward. The patient was a drummer in the Loyal Lancaster Regiment, and, let me add, that he stuck to his drum in the terrible retreat when everything, haversacks even, was thrown away, and all they could do was to limp along. This man stuck to his drum until he reached the Marne, but in crossing that river he got into the water and lost his drum. He came in with a terrible smash of his left humerus six days old; the wound was suppurating freely and extremely foul. He was hit by a fragment of shell; it had gone through the skin and literally powdered the bone. There was swelling and redness of skin and free suppuration, but the joint was free.

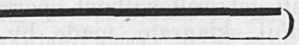
Under an anæsthetic one small opening for efficient drainage was made and a rubber tube put through. On doing this my finger entered the injury, and one could feel that the humerus had been smashed into a hundred fragments. I left them alone, and did not disturb the area more than obliged. That was the teaching of the septic period I had been through. The outstanding feature of his case was that his temperature was practically normal, *i.e.*, 99°, his pulse was good, he looked very wasted and ill, but there was no general septic infection, and so

we stuck to the arm. I had excellent orderlies—one from Guy's, Mr. Hensham, and the other, Mr. King-Brown, of St. Thomas's. And we dressed this man together every day for a fortnight, using an inside angular splint, with other three short splints.

He steadily got better, and went away with a sound arm, without splints, but still with one small sinus. He was washed out first with mercury, 1 in 1,000, and from that time to the end he was washed out with peroxide of hydrogen. That is a very good example of what seems the best way of treating these cases. And while I am speaking of that I would give you a practical hint with regard to splints, for the comfort of the patient is modified by the splints used. The splints are beautifully padded, but if you look at them you will see that they have this shape :—



The main contact with the soft parts is at the centre, the pressure is not uniform, and causes pain and impairs fixation. The linen cover should be loose at the ends, preferably open so that the padding lies flat, thus:—



When I was at work at the hospital I had the splints made in the accident ward with the ends left open, asking the sister never to sew them up; then I could fill up the hollows and make the splint fit the limb.

There were some severe cases of fracture of the upper third of the humerus. When the fractures are in the lower part it is easy to deal with them by means of plaster of Paris, or with wooden splints, but in the upper part it is difficult to keep the patient comfortable and to dress them without great pain. Two cases were made perfectly comfortable by extension. The patient lying in bed, the arm was placed on a locker, which had been cut to the proper height, a slight extending force applied to the wrist. Although one of the boys lost three inches of his humerus, from the anatomical neck downwards, he had a good sound arm in the end, new bone having formed.

The next case shows a broken tibia. A bullet passed through the bone splitting it into several fragments. The wound was particularly offensive, so that one had to turn away from his bedside. The natural tendency would be to open up and clean out the wound, and, perhaps, remove one or two fragments. But his temperature was not raised, and there was no general septic infection. He was left alone, except for putting on a boracic fomentation. He recovered rapidly, and walked away with only a small sinus, and with no dead bone to be felt.

I will mention one other septic case, and then I want to say a word or two as to why they are septic. The man is still in hospital, with a very bad fracture of the lower third of the femur, sustained early in October. Although it suppurated and was very foul, the leg was not amputated. Sir Frederick Eve, whose case it was, thought it would be better not to amputate. He was hit by a shell or a bullet in the retreat, and for ten days he had to lie in a cave, wholly untended. Other cases have laid out in the open for two days, three days, without attention.

I show you again this skiagram (see GUY'S HOSPITAL GAZETTE for March 13th, 1915) to remind you how bad some of the cases look; it is a bad injury of the carpus, with part of the radius and carpus destroyed; but this skiagram gives you no conception of the appearance when he came in. This patient, an officer, was reforming his men after that big reverse, when the Indians came back and our men were called to help. By the way, he has received the D.S.O. When he came in all the tissues were swollen and red, and it seemed that he must lose his arm; in fact, he had been told on his journey over that amputation would probably be performed on arrival in England. However, he was treated by baths, pretty constantly, and mended very slowly, and as he had no particular temperature, I left him alone, though there was a temptation to open up and pick out the loose pieces of bone. But I did not succumb to that temptation. Three weeks afterwards, when I thought the danger of increasing septic infection by interference had passed, especially the danger of the supervention of tetanus, I scraped the wound out very gently, and put the arm and hand in plaster of Paris. A solid aluminium drain was inserted. We left him with this plaster of Paris for one day, two days, three days. The immediate effect of my scraping was to send the temperature up to 103°, and the next day it was 102°. It shows that if interference had been undertaken in this case sooner, the result might have been serious.

The next case is a very good example of the explosive effects produced by a bullet, and I have the man here for you to see. A bullet

entered the anterior aspect of his forearm, and, passing through, struck the ulna and smashed it into fragments, and at the same time split the skin from elbow to wrist. When one saw the great pouting wound, with the muscles rolled out, and fragments of bone everywhere, one felt it must be a case of explosive bullet (Fig. 8), but I feel convinced, in the light of greater experience, that it was not the effect of an explosive bullet. The man himself thinks it was caused by a shrapnel casing. When I saw him the arm was three times its normal diameter, and there was great bulging and tearing of muscles. The explanation offered for these is that they are close range injuries, at 100 or 200 yards, and the bullets in their passage cause these big wounds; and if they hit a bone on the way through they smash it and drive it out. This man's arm was left severely alone, and you see what a good result has been secured. The skiagram shows some fragments of bone, the line of the ulua restored, no bullet, and no metal casing. His fingers were contracted to start with, but now you see the movement is perfect.

The next case I cannot show you. It was that of a man who was hit by a bullet, which entered below his trochanter. He came in with an enormous wound on the outer side of his thigh, with the muscles bulging out in huge masses, and with the whole leg and both feet swollen. For three days and three nights he had lain in the open, quite unprotected in any any way. He was found by a bearer company three days afterwards, with thirty other men in a wood which had been recovered. The Germans had first attacked us and driven us back; we recovered the wood, and then the men were found. I thought this also must be an explosive effect, but on opening a definite abscess which had formed, all I could find, in that great wound, was this little piece of metal; it is the nickel casing of a bullet. So, happily, here also I had to give up the idea of an explosive bullet having been used. He died of a terrible form of cellulitis, not exactly gaseous gangrene.

Sir Anthony Bowlby, in his very interesting account, said that many of the simple bullet wounds look exactly like shell explosions. I may tell you of an officer who came under me with the biggest wound of the buttock I have seen. It was quite four inches square, and you could look down to the bottom of this cone until you saw, apparently, into the fossa, and almost into the pelvis. He was walking in front of his trench, when he felt as if he had been struck a great blow on the buttock, and turning round blamed one of the men in the trench for shooting him. When he came in one could not find the point of entry of the bullet; the patient did not know where it went in. But next day there was a considerable swelling above the right testicle, and there could be no doubt that the bullet had entered from the front, had injured the right testis, where blood was extravasated, and passed underneath the urethra, across the groin on the left side, and had come out through the buttock. There, probably, in its course it had turned round and come out sideways, blowing away a large amount of buttock tissue.

There are many other instances, but the only other one I will show you is that of a man with a bullet in his lung, and the question is, as to what we should do for him. He was hit by shrapnel bullet and some fragments. He came in with a moderate amount of hæmoptysis, and much pain in his chest; he had a moderate temperature, and spat up a good deal of blood and much pus. We have watched him for some time. He still has cough, and some temperature, and he feels a strain when using his arm, but we hope he will get well without operation. Here is a beautiful skiagram, made by Sir James Mackenzie Davidson, showing the position of the fragment. The side has shrunk to some extent due, Dr. Newton Pitt thinks, to fibrosis of the lung.

You see the point of entry of the bullet in this lung case. While advancing they suddenly came under shrapnel fire and were ordered to lie down. They did so, and the shrapnel burst over them, and, as you see, the bullet entered just below the scapula; he had his arms extended at the time. (This man was invalided out in March, 1915, with shortness of breath on exertion and further contraction of the lung, but without expectoration or pyrexia.)

Now for a few points on the general question. Some adverse criticism has been passed as to the condition in which these patients arrive. I am sure you have but to read two papers, one by Sir Anthony Bowlby and the other by a French surgeon, Professor Moncier, in the last number of the *Lancet* to see that everything was done for these wounded men at the front that could be done, with our present knowledge. That does not mean to say we are not going to do better. Think of the want of space that a hospital of 200 beds has to expand in one day to receive 1,000 patients, and that those thou-

sand patients have to be sorted and treated, and the next day every single one that can be sent away has to be sent away in an ambulance to get ready for the next thousand; one can then see how want of space and small facilities for treatment, and the rapid evacuation necessary makes it almost impossible to deal with all the cases. Very few can be dealt with under anæsthetics, for instance. Sir Anthony Bowlby told me two weeks ago that in 23 days they had handled 27,000 wounded men. Think what that means in your clearing hospitals. I think those who feel inclined to criticise the condition in which the wounded arrive from the front ought to go to the front and see what they can do. As the French surgeon said to whom I have alluded, "there is one surgery of the front, and another surgery of the base hospital"; and if, in this war, those who worked at the front will compare notes with those who have worked at the base hospitals, we shall be able to arrive at some conclusions.

My time has practically gone, but I should have liked to have mentioned the case of a man who was shot through the axilla and lay out in open from five o'clock in the morning till seven in the evening with a bullet through the first part of his axillary artery. He came to England, was operated upon, and got well. But how could it happen that that wound could be anything but septic?

This is a terrible war, in many aspects, one of them being the absence of any armistice for treating the wounded. Whether the wounded in the trenches be German or English, it is impossible to succour them except at night, and even then it is very difficult, and so our wounded must lie out in the open. This man had a waterproof sheet over him, and, as it was raining, he managed to get a little water as it trickled from the waterproof. Yet, as I have said, when these cases arrive, there is no septicæmia about them. Why are the wounds so septic? The conditions under which the wound is inflicted is one thing; inability to dress them is another. Then there is the fact that the clothing is dirty and often penetrates the wound. We have taken from these wounds bits of khaki, boot hooks, and the other day hair from one of the men who had been wearing one of the goatskin coats. This and the bacteria which swarm in the soil will explain the infection. One begins to think that the iodine so universally used is not the best remedy, and we must look for more effective antiseptics.

A word on this subject. When considering the antiseptics in use, one must consider the vehicle which carries it. I am convinced that carbolic acid, which has stood the test for so many years, is the best of the antiseptics. Personally, in all my surgery, here and elsewhere, I have not abandoned the antiseptics carbolic acid and mercury. To put a sterile dressing on to a wound which is suppurating is not doing very much good—the septic processes will go on underneath that dressing just as if you had not put it on; whereas, using an antiseptic checks the development of those processes. A third, which is much recommended by some, is permanganate of potash. It has been pointed out that it is better to use both carbolic acid and mercury, because one is fatal to one form of bacillus, and the other is fatal to another form. Spirit and iodine has a great vogue at the present day, and I want to know from somebody how much is due to the spirit and how much to the iodine. I think more is due to the spirit than we are inclined to attribute to it, and I often think of the good Samaritan who nourished the traveller by the wayside and poured oil and wine into his wounds. I think he was the first antiseptic surgeon in history. Oil is an excellent vehicle, and we know spirit is a good antiseptic. Moncier says he had a friend who, in the country, was hit by a charge in the foot. He took the spirit used for an ordinary lamp at a farm-house and deluged the wound with it. After that he was taken home by rail and further dealt with, but the spirit was, no doubt, a definite factor in his getting well.

Another very interesting point is as to the value of ether. You know Whitehead's paint, which is a combination of iodoform and ether, that he used for his tongue operations; and though the iodoform is the principal agent, the ether probably had also a good effect.

Another paper which you should read is one in a recent issue of the *British Medical Journal*, by Mr. Waterhouse, surgeon at Charing Cross Hospital. He has been using ether in the septic cases, and his results are so remarkable that no one who is reading surgery at the present moment can afford to ignore them; for instance, pouring a pint of ether into a gangrenous wound in a man's buttocks who had been gored by a bull; and pouring the same substance into an appendicular abscess; injecting two or three drachms of ether into a suppurating knee-joint.

So I would say, in conclusion, that if we have cleaned out the wounds, we should be most careful not to disturb them; and, we should be very loth to remove injured tissues. After washing out with antiseptics we should use the mildest antiseptics for the daily dressing. That we should, if possible, immobilise the wounds, especially if it be in a limb, and dress them as seldom as possible. I think there is much doubt about the final dressing. I am trying, in the forearm cases, instead of the daily bath, which is the common practice, filling these wounds with dry powder, such as iodoform, boric acid in equal parts, after washing, immobilising them in plaster of Paris, and leaving them for from one to four days. In one case in which I did that the result was as good as you could wish to see.

And there is one word about amputations. There is a general impression that too many amputations are being performed in these septic cases, and I have told you of one or two cases in which it was thought amputation would have to be done. Septic as these wounds are, offensive as they are, the man is not poisoned; he has not got septicæmia, or pyæmia. So you can stick to his leg or his arm for a long time, and the quieter you keep it, doing nothing more than adjust the parts and removing any splinter which is lying close to a vessel for fear it may perforate it, the better it will be for him. Do not attempt to remove all the pieces of bone, because they will form new bone. Therefore, on the whole, one is inclined to amputate very seldom.

I would like to say, in conclusion, that I have appreciated very much this opportunity of once again lecturing in my old School.

Three Cases of Cerebro-spinal Meningitis.

PERHAPS a few short notes with regard to three cases of cerebro-spinal meningitis, that have recently occurred on a training ship, may be of interest. In the first place, I may say that the *Warspite*, off Greenhithe, is a training ship for boys for the Royal Navy and the Mercantile Marine. The age at admission is from 14¼ to 16 years. New boys are admitted every fortnight, and the average number on board is 230.

1. N. W., æt. 14 yrs. 10 mos., joined the ship on December 1st, 1914, and from that date never left the ship "on leave." Early on the morning of February 19th, 1915, he was taken ill on board and remained unconscious for some two hours. He had violent epistaxis and some vomiting. He was removed to a hospital we have on shore, and when I saw him he had a temperature of 101·6°, slight sore throat, and some pain at back of head. The same night his temperature ran up to 104°, and on the morning of February 20th he had a temperature of 101·6°. No rigidity, no Kernig's sign, symptoms indefinite. Through the kindness of Mr. C. J. Pinching the boy was admitted to the Gravesend Hospital the same morning as ? meningitis. By 11 p.m. he had become much worse; temperature 105°, and definite signs of cerebro-spinal meningitis; Kernig's sign; rigidity of muscles of back and neck. As there were some troops in the hospital he was removed to the Port of London Sanitary Authority's Hospital at Denton on the morning of February 21st, where he was under the care of Dr. Willoughby. A lumbar puncture was performed, and some anti-meningococcic serum was injected. The boy eventually made a good recovery.

2. A. S., æt. 15½ years, joined the ship from his home at Windsor on February 15th, 1915. On February 24th he complained of feeling ill, and when I saw him on board at 1 p.m. he had vomited three times. Temperature 100°; no definite signs. By 3 p.m. his temperature had risen to 101°; he had fairly marked Kernig's sign and rigidity of muscles of neck and back, with some headache. He was inclined to be drowsy. He was immediately removed to the Port of London Authority's Hospital at Denton. Lumbar puncture was performed and he was injected. He also made a good recovery. The cerebro-spinal fluid was sent up to the Local Government Board in both these cases, but the meningococcus was not found. The question is how the first boy was infected. Was the second boy infectious when he was admitted to the ship, and did he infect the first boy before he himself developed any symptoms?

3. A. C. V. P., æt. 15 years, joined the ship on March 24th, 1915, from his home at Hounslow. On March 31st he was admitted to the shore hospital with an attack of follicular tonsillitis. His temperature was raised for six days. On April 3rd his evening temperature was 104°; from April 6th to April 10th his temperature was normal, but from that date it ran up at night; on April 10th, 102°; April 11th, 101·8°; April 12th, 103·2°; in the mornings it was never higher than 99°, and once it was normal. From April 13th to 17th inclusive the evening temperature was 104°, with a morning temperature varying from normal to 99°, save that on the morning of April 18th it was 101°. About April 11th this boy had some rigidity of the neck muscles, which, however, passed off in two days. From April 12th to 18th he had some vomiting, with occasional pain over the forehead

and at the base. He had no Kernig's sign and no rigidity of back muscles. One curious point was that for three days previously to April 18th he had a paroxysm of pain (frontal) which almost always came on at noon, and lasted about half an hour, with a typical meningeal cry. The symptoms were very indefinite, but pointed rather to a T.B. meningitis. So Mr. C. J. Pinching kindly took the boy into the Gravesend Hospital on April 18th. On the 20th they did a lumbar puncture, and sent the cerebro-spinal fluid up to the Clinical Research Association, who reported that "an organism was found not to be distinguished from the meningococcus." On the strength of this report it was decided that it must be cerebro-spinal meningitis, and the boy was transferred to the Port of London Authority's Hospital at Denton. Mr. Pinching tells me that before he left the Gravesend Hospital there was an indefinite Kernig's sign and that his knee-jerks were exaggerated.

Case 3, after progressing fairly well for a week, had a recrudescence, rise of temperature, and pains at back of skull. He has had two injections. The cerebro-spinal fluid from the last two punctures was absolutely clear. Dr. Willoughby tells me the boy benefits from the punctures and injections. He seems to be rather a chronic case, and I am wondering what the ultimate result will be. Even with the return of symptoms he has had no rigidity. Optic neuritis is present in both discs.

These three cases present some very curious points. The onset of symptoms in Case 1 was slow at first and then rapid. In Case 2 the symptoms developed very rapidly and were definite. In Case 3 it looks as if the boy had a very mild attack, and that it was becoming almost chronic. For 18 days he had most indefinite symptoms, and I doubt if the diagnosis could have been certain unless the bacteriological examination of the cerebro-spinal fluid had proved positive.

One other point is that two of the boys were fresh admissions, and both had come from military centres. The infectivity of this disease, judging from these three cases, does not appear to be very active, for if it had been one would have expected rather a rapid spread amongst boys on a training ship. Up to now there have been no fresh cases.

In Cases 1 and 2, when lumbar puncture was performed, the fluid was turbid, and this was evidence of pressure, but in Case 3 there was very little pressure, but the fluid was turbid.

It is very easy to be wise after the event, but still I suppose the diagnosis ought to have been made by me, in Case 1, at any rate. Case 3 was, however, very puzzling, especially taking into consideration the long course that the disease took. I may say that there was no rash in any of these cases. H. T. SELLS.

Northfleet, April 29th, 1915.

Guy's Hospital Past and Present Nurses' League.

Annual Meeting and Dinner.

WE are quite sure that on St. George's Day, April 23rd, the thoughts of all League Members were turned towards their Training School, and before their minds were mental pictures of the Home and the scene in the well-remembered Dining Hall where the Annual Dinner takes place.

As was fitting, the keynote of the evening was patriotism, for in service and devotion to their country so many familiar friends were absent, working for our soldiers and sailors at home and abroad or unable to leave everyday posts because of the insufficient help now inevitable. As an emblem, the Home Sister had decorated the tables with the most perfect red roses, the patriot's flower, and very bright the Dining Hall looked, the maids each wearing a rose on her apron bib. To Matron had been presented a beautiful white rose tied with scarlet ribbon.

The menu cards showed our soldier saint in white and gold relief on a scarlet map of England. They were greatly admired and eagerly collected as "souvenirs" at the close of the feast.

But, as the children say, "begin at the beginning," and so we must go back to the entrance hall and the well-known crowd that collects to await Matron and the special guests. General welcomes all round, the present sisters in the cleanest of aprons, conscious of their virtuous and unusual efforts to be down punctually at 7 o'clock. The arrangements made to sit with those of "our set," and inquiries as to "what are you doing now?" The pass words are certainly "do you remember," but they are not spoken with regret, for they do not refer to the lost days of our life, but to opportunity that has made the present possible.

Sister Kiddle was surrounded by well-wishers, everyone anxious to hear of her experiences and to obtain news of friends on active service. It was a pleasure to see her looking well, and to have her with us to represent the nursing at Guy's at its best. Her five days' leave must have gone only too quickly, and we are glad to hear she has got safely back to France. Nurses Savage and Maddison, who, since their training have been on the Staff of the Institution, and had a few hours before reporting themselves at the War Office as members of the Civil Hospital Reserve, received many good wishes for their journey the following day and the work awaiting them.

After dinner two toasts were proposed by Matron and honoured with enthusiasm, in lemonade: "The King," and "Absent Friends."

At dinner and the after-meeting Matron was supported by Miss Swift, in the chair, and Miss Rogers and Miss Huxley of Dublin. Our first party of nurses to go out in August last will remember their kindly welcome to Dublin by Miss Huxley, where they were mobilised before embarking for a port in France.

Miss Swift, as Miss Haughton reminded us, retired from active work at Guy's, and now in these strenuous days finds her experience claimed for the responsible post of Matron-in-Chief of the Joint War Committee (the Red Cross and St. John's Ambulance Societies). Miss Rogers is her valued assistant. Seeing the Past and Present Matrons of the Hospital together, the thought must have struck all that had time and circumstances permitted, both would have rendered personal service to the wounded, but in undertaking the more difficult work of organisation they had given that opportunity to others. Most of the past members of the League owe to Miss Swift all that their training stands for, Miss Haughton representing the activities of Guy's at the present moment and the nurse to be.

We are proud to know that some 130 of our members are in France on active service and at least 150 engaged in nursing the sick and wounded at home.

From the Annual Report of the League we quote various extracts likely to be of special interest:—

The issue of the new "Nursing Guide and Register," due this year is postponed until after the war. The addition of an extension to the Cottage is also postponed owing to the great increase in the cost of building materials.

Naturally the various societies have suffered during this special year, and for the first time since 1895 there have been no practices and concerts given by the Musical Society.

The photographic and needlework competitions had been given up.

Interesting activities to report were that Sister Angove has now got the new Massage Department in full working order, and the second batch of students have commenced their six months' training.

The Nurses' Missionary League had sent a useful box of garments and bandages, as the result of a whole-day working party, to Mrs. Walker, née Nurse Kirby, at Hing Hwa Hospital, China.

The tennis court at the Cottage is in good order and much appreciated. Guy's holds the Silver Challenge Cup presented by the *Nursing Times*. This year the *Nursing Times* announces that tournaments will not be arranged.

It is impossible to mention individually all interested in the League and their work on the Council. Mrs. Cosmo Bonsor, as President, is indefatigable in attending the business meetings, and to the Hon. Treasurer, Mrs. Fagge, our thanks are due for our satisfactory financial position. The debt on the Cottage at Honor Oak Park is now reduced to £1,000.

Among the after votes of thanks none was received with greater acclamation than that moved by Miss Evans (late Sister of the Laundry Maid's Hostel) to Miss Smith, Secretary to the League. The League without Miss Smith would, indeed, be the proverbial home without a mother, and her special interest and skill in photography has made that section of the League the great artistic success that it is. The meeting felt in the absence of Miss Enid Newton it would be cheated of the opportunity of the enjoyable laughter that her remarks always give, but Miss J. Allen, of Queen Charlotte's Hospital, did her very best to cheer those who must perforce remain at home, although she addressed them as "slackers," and included herself in the category. This her audience would not allow, as her present post is important. She was at that moment attending her first annual dinner, and she confessed that she once assisted to rescue a distinguished Guy's surgeon from the fireplace of a ward that shall be nameless. So, in spite of a friend assuring her that she had been seen "grinning" in a train *en route* for the front, we were glad she was present to move the vote of thanks to Mrs. Fagge, and, incidentally, to give us a merry five minutes.

In bringing the meeting to a close, Matron (Miss Haughton) sent a special message by Sister Kiddle to all of Guy's that she would meet on her return to service, and the GAZETTE, we hope, will carry it to many others:—"Love and all good wishes from the League, constant remembrance in absence, thanks for all that had been done to preserve the best traditions of Guy's, and the confidence that whatever the difficulties of the future might be we could look to all absent League members at home or abroad to uphold the honour of their hospital."

PHOTOGRAPHIC EXHIBITION.

A competitive Exhibition was not held this year, but members were invited to send prints for show only. Photographs from France were sent in by Mrs. Hill, Misses J. Paterson, Shackleton, and K. Bishop, and of the Indian Hospital at Netley by Miss E. V. Smith. Sister Mary (Miss Edmonds) showed some beautiful prints of London from the Banks of the Thames, and Mrs. C. H. Wells exhibited also.

There were some interesting photographs of India sent by Miss K. B. Webb and Miss Delamere, of the Mayo Hospital, Lahore. Miss Smith showed some delightful views of Bruges. An added interest was the exhibition of the Portfolio of the 1913 Competition Prints of the Affiliated Societies of the Royal Photographic Society which were greatly admired.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR,—I was much interested in Mr. Finnemore's article on some old G.H.P.'s. He says, "very little remains to be said of succeeding editions," and mentions the introduction of the famous "Mistura Acidi Composita" in the 1879 edition. There are at least two curious formulæ in this edition which are worth repeating. The first is the "Mistura Olibani"—

Olibanum (Frankincense), powdered ...	20 grs.
Honey	½ fl. dr.
Barley Water	to 1 oz.

What was its use? In the B.P.C. it is said to be used in the preparation of plasters and is an ingredient of incense and fumigating powders.

The second is "Cataplasma Carotæ"—

Common Carrots Water	a sufficiency.

Boil the carrots until soft, then pulp them.

One wonders what the special virtue of the carrots over the linseed poultice was.

Writing of carrots, reminds me of a story by a medical parson acquaintance, who assisted at an operation for ruptured intestine on board ship. A carrot was boiled, and shaped to size and inserted into the lumen of the gut and the intestine sutured over. If any surgeons still use decalcified bobbins, let them please note.

—Yours faithfully, C. EDWARDS.

Granville House, Bridport,
April 25th, 1915.

[*Olibanum mixture* was one of the oldest formulæ, being included in the 1791 edition. It was presumably used as a stimulating expectorant much in the same way as the present official Ammoniacum or Balsam of Peru mixture is occasionally used. It is difficult to say if any virtue was claimed for the carrot poultice over that of linseed; both were included in the 1826 edition, the carrot poultice being deleted from the 1891 edition.—Ed., G.H.G.]

Specialities.

A Casein Tonic Food.

The special efficacy of casein in the dietary of convalescents and in many fevers and other ailments calling for an easily assimiliable food of high protein content, has been so clearly emphasized by leading dietists that it may be superogative to recount the properties of casein which make for its extensive popularity. Not only is casein easily digested and absorbed, but it has qualities which, if necessary, render it capable of replacing with advantage all other forms of protein. First, it "fixes" the stomach acids, which is a special advantage in dyspepsia; secondly, it does not yield uric acid or other purins—hence its admissibility in gout; and thirdly, it contains phosphorus in organic combination, which enters the blood in organic form, thus providing a valuable source of this necessary constituent of the tissues. These characters are crystallized by Dr. R. Hutchison (*Food and Dietetics*): "In illness and especially, perhaps, in fever and diabetes, they [casein preparations] increase very considerably our dietetic resources, and are probably destined to take an important place in the treatment of disease by feeding. They are far superior to any meat preparation as condensed forms of protein."

Manufacturers, at first in Germany and later in the United Kingdom, have devoted time and capital to the commercial production of casein foods, and, at the present time, it may be claimed fairly that some of the British products are in no way inferior, and in a few cases superior, to those of foreign origin. The greatest successes, however, have not been obtained with pure casein, but, strangely, with combinations of casein and a glycerino-phosphate, usually the sodium salt. Experience showed, however, that such a combination was contra-indicated in some subjects with a tendency to constipation; and to avoid this objection it was desirable to include the magnesium salt.

Such a combination—casein with sodium and magnesium glycerophosphates—has been commercially realized in the tonic food, Vitafer, manufactured by Messrs. Southall Bros. & Barclay, Ltd. During the four years it has been before the profession it has been freely tested in convalescence after many illnesses—influenza, pneumonia, rheumatism, operations, etc.; in various nervous diseases—neurasthenia, neuritis, neuralgia, etc.; in digestive disorders—functional dyspepsia, gastric atony, gastric ulcer, etc., and in phthisis, with very gratifying results. C. E.

Notices.

Metropolitan Asylums Board.

INSTRUCTION IN FEVERS.

A Course of Instruction (two months) in the Diagnosis and Treatment of Fevers will be held during July–August, 1915, at the South-Eastern Hospital, Avonley Road, New Cross, S.E., by F. M. Turner, M.D., Medical Superintendent, on Tuesdays and Fridays at 11 a.m., beginning Friday, 2nd July.

Students who desire to attend this course of instruction must, before attending at the hospital, bring, between 11 a.m. and 4 p.m. on any week-day (except Saturday), or send by post; to the Clerk to the Metropolitan Asylums Board, Victoria Embankment, E.C.:—

1. Authority from the Dean of the Medical School.
2. Fee—£3 3s. for two months' course Cheques to be made payable to "The Metropolitan Asylums Board."
3. Full name and address, and name of Medical School. (N.B.—The name must be in full, and must be distinctly written.)

Note.—It must be distinctly understood that no certificate will be granted to any student who has attended for less than two days in each week during the whole period of two months.

By order,
T. DUNCOMBE MANN,
April, 1915. Clerk to the Board.

Pass List.

Final Conjoint Examination.

April, 1915.

Medicine.

C. W. W. Baxter.
J. E. Clark.
*E. C. Cline.
T. H. Edey.
*D. R. Jones.
G. S. B. Long.
W. L. Partridge.
A. L. Punch.
T. W. Sheldon.
J. G. Stevens.
A. H. Taymour.

Medicine and Surgery.

*R. Curle.
*C. H. Edwards.
*R. A. Holmes.
*N. E. Kendall.

Surgery.

*W. A. Easton.
*C. C. G. Gibson.
G. D. Gripper.
*H. S. Groves.
*B. Mitra.
*E. C. Peers.
*D. O. Richards.
*H. Q. F. Thompson.
M. J. T. Wallis.
*K. J. F. Westman.

Midwifery.

K. L. Bates.
E. Biddle.
M. Chadwick.
E. M. Litchfield.
V. E. Lloyd.
F. A. Knott.
K. N. Purkis.

* Denotes completion of examination.

University of London.

SECOND EXAMINATION FOR MEDICAL DEGREES, PART I.

*W. H. Grace.

* Denotes passed with distinction.

NOTICES.

The following Prizes have been awarded :—

MICHAEL HARRIS PRIZE FOR ANATOMY.

Mr. F. Caldecott }
Mr. E. C. Hinde } equal, £5 each.

WOOLDRIDGE MEMORIAL PRIZE FOR PHYSIOLOGY.

Mr. E. C. Hinde	Prize (£10).
Mr. F. Caldecott	Certificate.
Mr. F. Deacon	Certificate.

JUNIOR PRIZES FOR GENERAL PROFICIENCY.

Mr. E. C. Hinde	£20.
Mr. F. Caldecott	£15.
Mr. R. Leblanc	£10.
Mr. F. Deacon	Certificate.

ENTRANCE SCHOLARSHIPS IN DENTAL MECHANICS, APRIL, 1915.

Open Scholarship, Mr. H. J. Powell	£20.
Pupils' Scholarship, Mr. G. F. Faustmann	£20.

STUDENT DEMONSTRATOR OF ANATOMY, MAY–JULY, 1915.

Mr. F. Caldecott.

Guy's Hospital,
27th April, 1915.

Reviews, etc.

Report on Odontomes. Published by the British Dental Association. 135 pp., nearly 100 illustrations. Price 7s. 6d. net.

This report is the outcome of the work of a small committee appointed in 1906, consisting of Messrs. Douglas Gabell, W. Warwick James, and J. Lewin Payne, "to prepare an extended and illustrated edition of the catalogue" which had been hastily compiled for the Annual Meeting of the Association in 1906.

Although many years have passed since the appointment of the committee, the report is an excellent one in every way. Due to the advance of knowledge in this subject, the Committee found that a classification differing somewhat from that of Bland Sutton was necessitated. The one adopted is set out below:—

1. Epithelial Odontomes.—Multilocular cysts; Dentigerous cysts; Dental cysts.

2. Composite Odontomes. — *a.* Complex composite odontomes; Compound composite odontomes. *b.* Geminated composite odontomes; Gestant composite odontomes; Enamel nodules. *c.* Dilated composite odontomes.

3. Connective Tissue Odontomes. — Fibrous odontomes; Cementomes.

After an introduction dealing with the classification, the report is divided roughly into three sections—Epithelial Odontomes, Composite Odontomes, Connective Tissue Odontomes. The various divisions of these sections are fully discussed, and each division is followed by a detailed description of its respective specimens that appeared at the 1906 meeting. The most interesting specimens have been photographed and reproduced.

An appendix contains an account of four cases of tumour arising from dental tissues, and described by names implying malignancy. This chapter is headed malignant odontomes, but the committee states that "a careful consideration of the cases which have been recorded shows that they do not possess the essential characteristics of malignant tumours. The establishment of a new group is, therefore, not warranted at present."

The illustrations are beautiful, and great praise is due to both photographer and reproducer.

In view of the new issue of the British Pharmacopœia, Dr. J. Mitchell Bruce, M.A., M.D. London, F.R.C.P., has, with the aid of Dr. Dilling, Lecturer in Materia Medica and Pharmacology, re-arranged and re-written his volume "Materia Medica and Therapeutics; an Introduction to the Rational Treatment of Disease," so as to bring it into correspondence with the new Pharmacopœia, and the tenth edition is about to appear. Those parts of the book which deal with the effects of drugs on the human body have also been re-written in accordance with the newest lights on the subject. Messrs. Cassell issue within the next few days.

Birth.

SECRETAN.—On April 24th, at Redlands Road, Reading, the wife of Dr. Bernard Secretan, of a son.

Marriage.

DYKE—HUTCHINSON.—On March 31st, at St. Stephen's, Norbury, Victor Robert Dyke, L.D.S.Eng., of Coulsdon, to Florence Ethel, elder daughter of Mrs. J. Hutchinson, of Brockley.

W. E. T.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE sympathy of everyone at Guy's goes out to Dr. and Mr. Lauriston Shaw, who have lost their eldest son, Reginald Shaw, killed in action.

On May 9th, Lieutenant Montague Pern, R.A.M.C., was killed. He was only 26, and was known affectionately by his hospital colleagues as "Freddy." There were sad faces in the College when the news of his death arrived.

There is a long list of wounded. Capt. Wood, I.M.S., Mr. Dennis Brown, R.N.V.R., and 2nd Lieutenant Paxton Bayliss, R.N.V.R., have been wounded in the recent fighting in the Dardanelles. Second Lieutenant F. W. Crook, 2nd K.R.R., 2nd Lieutenant H. P. Parkes, and 2nd Lieutenant Mew with the Expeditionary Force in France.

Several Guy's men are warded in the Officers' Section—Lieutenant G. P. Lindsay, Border Regiment; Lieutenant C. T. Watson, Surgeon Barrowclough, R.N., and Lieutenant W. Kelsey Fry, who was wounded soon after his return to the Front. A few weeks ago he came home to bring the body of Lieutenant W. G. C. Gladstone, M.P., to Hawarden Castle.

Fry and Corporal Welch, of the Royal Welsh Fusiliers, made a gallant attempt to save Lieutenant Gladstone, when he was shot, by carrying him out of the trenches in full view of the Germans, when there was thought to be a chance of saving Lieutenant Gladstone's life. His uncle wrote:—"All our family much appreciate the gallant action of Lieutenant Fry and yourself, and will never forget it."

TRENCH ODES.

He was shot in the head at daybreak,
And died with the sunset's glow;
We didn't know much about him,
For their wasn't much to know.

He was just out fresh from England,
And didn't quite know the risk,
But we got his name and his number
From his identification disc.

He was only a bit of a youngster,
And yet he'd the heart of a man;
There was never a word or a murmur,
While his life sands slowly ran.

We dug his grave in the twilight,
While his mates were "standing to,"
But when it came to the service,
We didn't know what to do.

So "Our Father which art in heaven,"
(Men all know how that goes),
We said, tho' t'was our only prayer—
I reckon "Our Father knows."

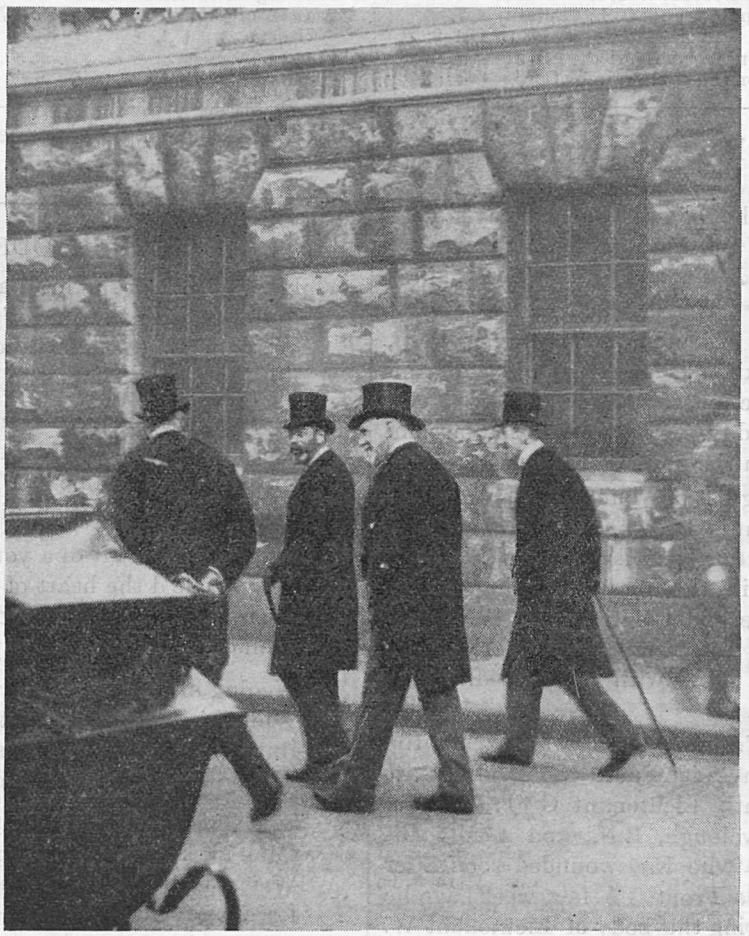
IN January last, the Commercial Union Assurance Company, the executors of the will of the late Sir William Dunn made a grant of £1,000 to the Dental Department for the treatment of soldiers and recruits with defective teeth. The result of this work has been so satisfactory that a further generous donation of £1,000 has been

made which will enable the Hospital to continue their very complete arrangements for this purpose.

The Resident Dental Officer has very kindly supplied us with a report of the work and expenses of the Dunn Bequest during the months of February, March and April. During this period 303 men were treated, and 359 anæsthetics were administered; gas on 326 occasions, ethyl chloride on 7, novocain 25, and intratracheal ether once. 1,633 teeth were extracted and 399 fillings put in; 30 upper and 26 lower dentures were inserted. The total expenditure for the above work is £115 1s. 9d. The value of dentures, either in course of manufacture or authorised for construction, is £750.

A study of the cases treated from February to May 18th shows how necessary such work is, for 78 men had more than 10 roots extracted; of these, one man had 32, one 26, two had 24, one 23, one 22, and three 21 roots removed. These 78 men averaged roughly 13 roots each.

The work has been chiefly done by old Guy's Dental men, who have volunteered their services for one half day a week.



The Royal Visit to Guy's on May 1st.

Special reference must be made to the amount of time and energy Mr. H. O. Salt and his colleagues have devoted to this work.

Our thanks are also due to the Guy's Hospital Ladies' Association, who have made a grant of £350 to support six beds and two cots in Victoria.

The Hospital maintains its friendly relations

with the City Companies. The Worshipful Company of Fishmongers has given £100 to the Hospital.

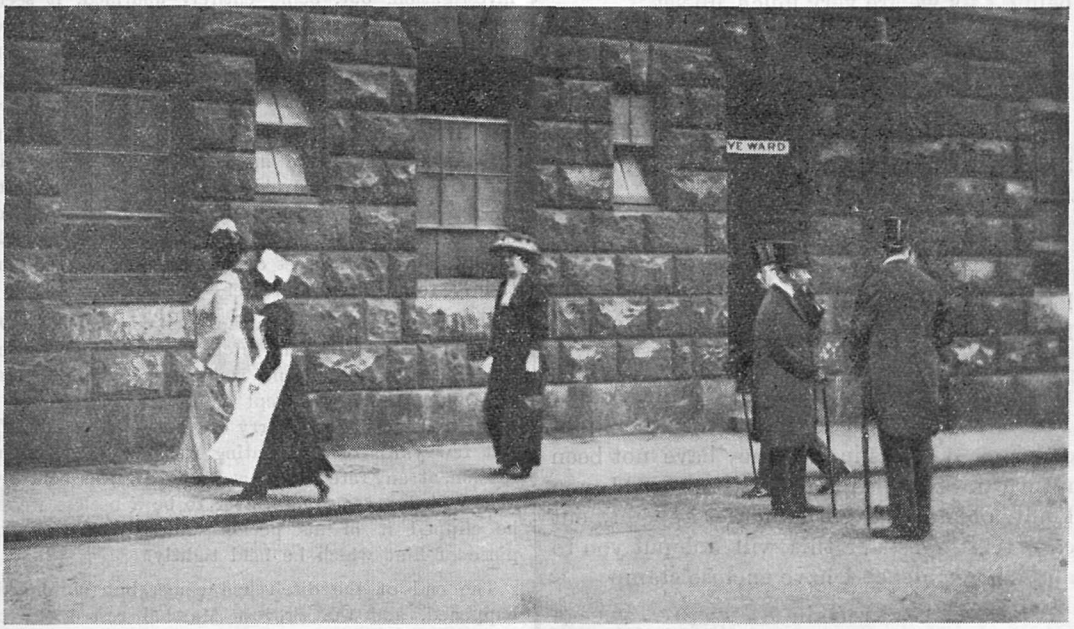
We heartily congratulate Mr. F. G. Larkin, who has been elected a Fellow of the Royal College of Surgeons. As a third year student, in 1869, Mr. Larkin read a paper before the Guy's Hospital Physical Society "On nephrotomy and excision of the kidney." An acconnt of his research appears in the 27th volume of the Gazette.

It must be quite unique to give the F.R.C.S. to a general practitioner for work done during his student days.

College before he became officially connected with the Hospital.

In a farewell letter to the Superintendent he says:—"What I have done, there, with your kindly advice and assistance, has, I hope, been all to the good of that fascinating old place. *Dulcedo loci me attinet.* I should like to convey to everyone at Guy's my gratitude for the unfailing courtesy and consideration which made my work so pleasant there. My thoughts are often, as they have been for years, with the place and its people."

Mr. Philip Turner was gazetted Major in R.A.M.C. on May 18th.



Congratulations to Mr. D. M. P. Whitcombe, who has been awarded the Beaney Prize in Pathology, 1915.

The retirement, under the age limit, of Mr. John H. T. Woodd, is a serious loss. Mr. Woodd, who has been architect to the Hospital since 1894, has taken an important part in the construction of the large number of new buildings and extensions erected during the last 20 years. Mr. Woodd designed the plans of the

Dr. Iredell has been appointed Officer in Charge of the Electrical Department in place of Dr. Hertz, who has resigned. We hope men and nurses will avail themselves of the opportunity of having instruction in this important branch of therapeutics.

Departmental Libraries now exist in the Chemical, Pathological and Physiological Laboratories. From time to time Guy's men have presented books and instruments to these

departments—a microscope was presented to the Physiological Laboratory a few weeks ago. These gifts are so valuable that we venture to appeal for more of them. Perhaps it will be possible later on to make a collection of war trophies for the Museum.

Another empty bed!

"Dear Sir

I thank you for the letting me know that you have reserved a bed for me. I should be glad to come only we have had Burglars in last Saturday morning and should be glad let some one else have the bed for the time being. As we are very much up set

I am yours Truly

_____"

Sister Out-Patients' sends us the following letter:—

"To Sister

I am sorry to write and tell you I have lost my appointment card with Dr. Thetwen for Antesetic for May 31st the number is 45 I wonder if anyone had Pick up the envelope it as Dr Eyere Dr French Dr Sir Cooper Perry also an appointment for the light department Cards in it if they have not been return to the hospital. Sister could you kindly oblidge me with another appointment card trusting sister this will not put you to any inconvenience I have enclose stamp

I remain

yours sincerely

_____.

I am afraid I have not spell Dr. name quite right."

We wonder who is trying to deprive this patient of her weekly visits to *five* of the Special Departments.

Harassed O.P.O.—"Come up to-morrow mother and see the Specialist."

Vignettes from France.

VIII.

He had crossed the road every day for the last week, the innkeeper told the M.O. with much waving of hands and interjections from his women folk. Even now he was hiding in a ditch, and the innkeeper added that his daughter was keeping a close watch on the ditch from an upper window.

The M.O. had started off from billets with an ambulance to collect some wounded who were in a convent about four miles away. On his way there he had been stopped at the inn, where he had been told of a spy who was trying to discover the positions of a concealed battery of artillery. They were all very certain that he was a spy, and certainly his conduct had been most surprising. Anyway it was worth a further investigation, but, being entirely unarmed, it seemed better to send on to the next village and obtain some assistance. This was forthcoming in about a quarter of an hour, when two officers—one a Provost Marshal—returned in a motor.

In the meantime nothing had happened in the ditch, and having heard the innkeeper's tale once again—which could not be avoided as he kept on repeating it—the available forces were divided, the two armed officers taking either side of the ditch while the M.O. followed a discreet distance in the rear clutching tightly to a service revolver—empty.

In this manner the battue was conducted, a very slow proceeding, as the ditch was wide and covered thickly by brambles and small trees. At the same time close watch was kept on the farther end of the ditch to see that the quarry did not make a bolt. The last few yards of the beating was done at very high tension, at any rate as far as the M.O. was concerned, and feeling an empty revolver to be a useless weapon, he slipped it in his pocket and picked up a nice piece of flint which he held tightly.

The end of the ditch had come, but nothing had happened, and the Provost Marshal rested the butt of his rifle on the ground and swore, while the other officer slowly put up the safety catch of his revolver. The M.O. felt aggrieved. It was he who had brought the other officers to the spy hunt, and it was obviously up to the spy to provide some excitement.

The ditch was beaten again carefully, but most of the excitement had gone from the hunt, and when the end of the ditch was reached again there was nothing for it but to give up the search for the day. All three accordingly made their way back to the motor, where the innkeeper again gave a graphic account of the spy and his clothes. The M.O. thought there seemed less interest in the tale than there had been at first.

Pass List.

Royal College of Surgeons.

LICENCE IN DENTAL SURGERY.

FIRST PROFESSIONAL EXAMINATION, APRIL, 1915.

Mechanical Dentistry and Dental Metallurgy.

†D. W. S. Adams.	†F. G. Knowler.
†C. A. D. Bishop.	†J. L. Lean.
*W. A. Cooper.	C. A. Loveluck.
†B. P. Cousins.	P. H. Marsh.
L. D. Crabb.	W. Mercer.
E. T. Crosoer.	*A. A. Osman.
*E. P. Deverall.	†E. A. P. Parker.
†P. J. S. de Wet.	H. J. Powell.
*J. A. Evans.	†R. S. Roche.
*G. F. Faustmann.	†E. F. Shaw.
†H. Fox.	B. M. Tonkin.
†E. S. Goodwin.	†H. V. Vogt.
†P. E. Grobbelaar.	†A. Weinberg.
R. J. G. Handel.	†G. Wilshere.
J. Herbert.	†T. A. M Wilson.
†J. C. Johnson.	†W. A. Woodward.
†H. L. Jones.	*W. R. Wotton.
†R. V. Kingham.	

*Mechanical Dentistry only. †Dental Metallurgy only

Society of Apothecaries.

At Examinations held recently the following candidate passed in the subjects indicated.

Medicine, Surgery, Forensic Medicine and Midwifery.

R. Quesada,

Surgery and Midwifery.

R. Curle.

Medicine and Midwifery.

J. B. Fairclough.

Medicine.

L. A. J. Graham.

The Diploma of the Society was granted to the following candidates entitling them to practice Medicine, Surgery, Midwifery:—

R. Curle, L. A. J. Graham, and R. Quesada.

Appointments.

Naval.

Surgeon H. L. Peregrine, R.N., H.M.S. *Victory*, additional to Haslar Hospital.

To be temporary Surgeon:—A. B. Danby to the *Vivid*, additional for Haslar Hospital.

Royal Army Medical Corps.

To be temporary Lieutenants:—Harold Webb, L. G. Davies, T. Stansfield, W. P. Taylor, H. V. Leigh.

Eastern Mounted Brigade Field Ambulance: V. M. Wallis to be Lieutenant.

1st North Midland Field Ambulance:—Lieutenant K. B. Clarke, from Eastern Mounted Brigade Field Ambulance, to be Lieutenant.

To be Captain:—G. T. S. Sichel.

Attached to other than Medical Units.

Louis B. Stringer resigns his commission.

W. G. Hollands, to be Lieutenant (S.R.) 7th Battalion Royal Fusiliers.

C. John Henry, Honourable Artillery Company, "A" Battery, Mediterranean Expeditionary Force.

Civil.

E. P. Hudson, L.D.S. Eng., has been appointed Clinical Assistant to the King George Hospital, S.E.

Wounded.

Captain C. A. Wood, I.M.S., 1/4th Gurkhas.

Short Notes on Thirty Cases of Soldiers Blinded during the Present War, 1914-1915.

BY ARTHUR W. ORMOND, F.R.C.S.,
Captain R.A.M.C. (T.)

OWING to certain arrangements made by the War Office, all soldiers who return to this country in a blinded condition are collected at No. 2 Base Hospital, Chelsea, before being discharged either to their homes or to the new hostel arranged for them at St. Dunstan's, Regent's Park. I have, consequently, seen a large number of these men, and I am recounting the medical notes of some thirty of them as likely to be of interest to Guy's men. At St. Dunstan's very complete plans are being made for teaching these men the various trades and employments possible to those who have lost their sight, and every help and encouragement is given them to "make good," as far as possible, what they have lost.

The majority of these soldiers have been blinded by bullets traversing the head from side to side in the region of the orbits. In some cases the eyes themselves have been touched by the missile, and then the destruction of the globes is usually complete, but often the eyeballs are not injured directly, and the sight has been destroyed indirectly by the vibrations of a high velocity bullet traversing a more or less fluid medium. In other cases the optic nerves have been severed behind the eyes, leaving the sclerotic intact, so that the patient when seen for the first time appears to have little wrong with him. In all cases the bullet has entered the orbit in some part of its cavity and if the orbit is not involved the eyes generally escape.

The causation of these indirect wounds is explained as follows: "If a vessel made of sheet lead, shaped like a jam-pot, left open at the top and containing nothing but air be fired at, the bullet makes a clean entrance and exit wound without distorting the outline of the vessel, but if the vessel be filled with water,

the top still being left open, the effect of a bullet at very high velocity is to rend the vessel to pieces."

The force of the projectile is partly changed into vibrations which radiate in lines from the long axis of the bullet tract so forcibly, that they act as secondary missiles. We must suppose that such lines of intense vibration impinging on the outer surface of the eyeball. though unable to cause disintegration of the dense sclerotic, can pass through it with sufficient force to produce rupture of the much less firmly knit choroid and retina immediately beneath. We must remember that during life the soft tissues in the orbits may be looked upon as being fluid, and the explosive effect of a bullet is proportional to its velocity, sectional area, and the amount of water present in the substance through which it passes.

We find, then, many of these men possessing wholely sightless eyes, while the outer tunics of the eye itself show no sign of any injury.

Some have also lost their sense of smell, the bullet having involved the superior nasal bones in its passage through the head, and others have received extensive injuries to the jaw, maxillary antrum, and skin of the face.

Some of the cases are of individual interest:—

Case 15 is of a man who received a wound in the occipital region and lost all memory of when or where it took place, and is only gradually coming back to a full realisation of events which happened to him some time after his injury. When first I saw him he was only able to see the difference between light and darkness, and it was difficult to arouse him out of a semi-comatose condition. Both eyes were quite normal and the pupils reacted to light. Now, however, he can see moving objects and contrasts on his left side, and his mental condition, although slow and dull, is still improving.

It is not uncommon to find a number of pieces of metal in an eye, and X-ray photographs show numerous other pieces in the walls of the orbits and in the tissues surrounding the globes.

Case 19 is that of a gunner who suffered from the too previous explosion of one of our own shells. He tells me the shell was defective and had only been placed in the breach ten seconds before the heat of the gun caused it to explode, killing one man and elevating W. G. some yards into the air.

Case 29 has been reported extensively in the East Coast papers, as he was a native of Norwich and was injured by the explosion of a dummy sentry. The changes found within the globes as a result of indirect injury are to be attributed to rupture of the retinæ and choroid. The choroid being almost entirely a vascular membrane, extensive intra-ocular hæmorrhage occurs as a result of any injury to it, and the vitreous chamber is at first full of blood, which subsequently is partly absorbed and partly becomes organised and decolorised, so that the interior of the eye, three or four months after the injury, is occupied in great part by a soft glistening white mass; beyond this mass the characteristic scars can often be seen.

Of all the cases of injuries to the eyes that I have seen, including a large number in which one eye alone is damaged, I have only had one case in which detachment of the retina was probably present, and that is Case 2 on the list. This is, I think, remarkable, considering the number of cases of injury to the eye, both direct and indirect, which I have seen. I have also only had one case of cataract.

To those of us who are working in Base Hospitals it is a matter of the greatest regret that we seem unable to do anything to improve the vision of these blinded men; the damage is so extensive and of such a nature that it precludes any hope of improvement. Two of the cases, 18 and 8, have improved slightly, to the point of seeing shadows, due probably to the effect of the absorption of the blood; on the other hand, two cases have lost the little sight they had, probably due to secondary changes, the result of contraction of the organised clot.

A great deal of work has, of course, been expended in cleaning up the wounds and curing septic discharges which, in some cases, were very profuse, but the main work of the surgeon now is to devise various plastic operations to diminish the disfigurement and to enable the men to wear artificial eyes.

The psychology of these men who have been blinded is very interesting. With only two exceptions, and one of these is probably the result of damage to the frontal lobe, all of them exhibit extraordinary cheerfulness and contentment. One man to whom I expressed the opinion that he was very unlucky, as his eyes alone seemed to have suffered any damage and he had escaped all other injury, seemed only to be occupied in congratulating himself on being still alive, his remark being, "I think I'm very lucky, sir, as I might have lost my head;" and another, who not only lost both eyes, but had as well extensive wounds of his face involving the whole of the maxillary antrum on one side always replys in the most cheery voice in answer to a query as to how he is, with the expression, "Oh, I'm in the pink, sir." I am quite sure that the arrangement by which these men are kept together from the start has been a great asset in combating the melancholy and depression which one would have expected to find. How long this mental phase will last one cannot say, but the main utility of the scheme, which is being organised by Mr. Arthur Pearson, at St. Dunstan's, Regent's Park, lies in the fact that before there has been time for a period of depression to supervene they will have been rendered less dependent on external assistance by being taught to be self-supporting and, to a greater or less extent, self-dependent.

Initials and No.	Age.	Rank.	Regiment.	Nature of Wounds.	Place.	Vision.	Remarks,
1 S.	28	Sergeant	2nd Scots Fusiliers	Transverse bullet wound through lower part of both orbits.	Ypres 14/10/1914	P.L. ?	Both globes are shrunken. Cornea contracted T-3 Anosmia, Ptosis.
2 M.T.	18	Private	Irish Guards	Transverse bullet wound behind both globes.	30/12/1914	P.L. with right eye. Nil c left eye.	Both eyes in situ. Retina and choroid disorganised. Vitreous chamber full of blood. Some retinal vessels seen 5+12 D. Left optic nerve severed. Left external rectus paralysed. Pupils inactive.
3 F.	36	Lance-Corporal	Leicesters	Transverse bullet wound through orbits.	La Bassée 27/1/1915	No P.L.	Right globe removed in France. Left optic nerve severed. Interior of globe disorganised.
4 H.	30?	Private	?	Bullet wound. Destroyed both eyes.		No P.L.	Patient was very depressed, gloomy and suspicious, and refused all offers of assistance.
5 R.O.	20	Private	Royal Fusiliers	Bullet entered right orbit and crossed to left side above the zygoma.	Armentieres 16/12/14	No P.L.	Right eye removed at the American Hospital at Paignton. Left eye in situ. Optic disc white. Large rupture of choroid and retina at macula. Anosmia.
6 G.A.	20	Private	1st Chesters	Bullet traversed lower part of left orbit and behind root of nose to a point just in front of the right ear.	Ypres 8/2/1915	No P.L.	Extensive wound of the right maxillary antrum, right eye destroyed. Left eye has a hole at its lower part to which the lower lid is adherent.
7 G.C.	25	Private	?	Shrapnel.	France	No P.L.	Was under Mr. Harrison Butler at Birmingham. The right lid was adherent to the shrunken globe. Left eye removed. Had extensive injuries to the root of his nose and face.
8 K	23	Private	Royal Munster Fusiliers	Shrapnel burst in his face and bespattered him with small metallic pieces.	Etreux 27/8/1914	Right eye P.L. Left eye can count fingers.	No foreign bodies found in globes by X-rays. Both eyes in situ. Small prolapse of iris in left eye, which was removed. Vision slightly improved the last two months. Was seen by Col. Lister in France. Extensive scars on face.
9 K.	32	Private	1st Royal West Surrey	Transverse wound by bullet through both orbits.	Ypres 31/10/1914	No P.L.	Both eyes entirely destroyed. Typhoid fever developed after his return.
10 B.	29	Sergeant	1st Rifle Brigade	Bullet entered on left side one inch behind ext. angular process and crossed to right orbit, leaving at right external angular process.	Ligny 27/8/1914	Can see light on outer side with left eye only.	Was unconscious for seven days after injury, and does not know when the right eye was removed. Left globe in situ. Large mass of organised blood on the inner side. Ptosis of left lid.
11 H.	20	Lance-Corporal	Sherwood Foresters	Shrapnel burst in his face.	Lille 10/12/1914	Shadows at 2 ft.	Left eye excised at Namur. Extensive wound right side of face as far as the ear, but the right eye remains in situ. Pupil reacts slightly. Large white mass in fundus.

Initials and No.	Age.	Rank.	Regiment.	Nature of Wounds.	Place.	Vision.	Remarks.
12 J.B.	23	Private	3rd Royal Sussex	Shrapnel burst in front of him as they were preparing to charge with bayonets.	Ypres 30/10/1914	P.L. c right eye.	Both globes are shrunken and have deep contracted scars. Jaw also fractured and tip of tongue lost.
13 H.D.	31	Private	3rd Rifle Brigade	Bullet hit the magazine of his own rifle and the whole thing exploded in his face.	Lille 29/10/1914	P.L. c left eye.	Was under care of Mr. Hudson at Moorfields. The right eye was removed on account of pain. Numerous foreign bodies in shrunken left eye.
14 H.	25	Private	1st Wiltshires	Bullet entered left orbit and smashed through the root of nose into right orbit.	La Bassée 19/10/1914	Nil.	Both eyes removed at Aldershot.
15 L.	31	Private	Munster Fusiliers	Bullet entered occipital region, and he was operated on at the front, but no records came with him and he can remember nothing. Eyes are quite normal.	? About Jan. 26th, 1915	Right eye Hemianopia. Can see the outline of objects only.	Patient was quite blind when first seen 12/2/1915, he has since recovered some vision. Has extensive scars on the scalp all over the occipital region. His mental condition is slow and deliberate but he is improving.
16 W.	19	Private	Scots Guards	Bullet entered the left orbit, passed through root of nose into right orbit.	La Bassée 21/1/1915	Counts fingers at one yard.	The left eye remains in situ, but has a corneal scar on inner side; the fundus of this eye shows rupture of choroid. Right eye destroyed. Smell not affected.
17 I.		Private	Rifle Brigage 3rd Batt.	Bullet entered right orbit and left through maxillary antrum on left side. Jaw also damaged.	Dixmude January	Objects at 20 yds. with left eye.	Right eye destroyed. Left optic nerve atrophic. Large mass of organised blood clot in vitreous chamber. Sight has improved a little lately. Anosmia.
18 L.	40	Private	Essex	Hand grenade exploded in his face. Whole face discoloured by gunpowder, etc.	Bizet 16/2/1915	P.L. only.	Right eye destroyed. Left cornea riddled with small pieces of metal. No red reflex obtained. Jaw broken and teeth knocked out.
19 W.G.	24	Gunner	R.G.A.	4·7 lyddite shell exploded owing to heat of gun just as he was going to fire it.	Neuve L'Eglise 10/3/1915	Nil.	Both eyes entirely destroyed. Face very much burnt. Was blown into the air by the explosion.
20 T.G.	26	Private	King's Own Rifles	Bullet entered on left side, passing through orbit and above right orbit probably damaging frontal lobe of brain. Had a depressed fracture also. Trephined.		Moving objects at 3 yds. below.	Left eye destroyed. Compound comminuted fracture of skull on left side. Mental condition altered, very restless and irritable. Right ptosis. Vitreous chamber full of blood, red reflex above only.
21 C.V.	25	Belgian Soldier	?	Bullet through orbits, which entered on the left side over the left brow and passed out in front of right ear.	Dixmude	Nil.	Left eye removed at No. 4 Base Hospital (King's College). Right eye in situ. Pupil fixed and inactive. Large mass of organised blood on outer and upper side of fundus; on inner side the choroid can be seen to be ruptured. Nerve probably severed.

Initials and No.	Age.	Rank.	Regiment.	Nature of Wounds.	Place.	Vision.	Remarks.
22 G.S.	25	Private	Northamptons	Explosion? The man himself talks of an explosive bullet.	Neuve Chapelle 15/11/1914	Right eye can distinguish contrasts at 2–3 yds. Left eye P.L. ?	Was operated on at Aberdeen, probably for removal of metal from the lids and orbit. Both eyes in situ. Right eye has hæmorrhage in the vitreous chamber. Sight of right eye is worse than it was. Right pupil reacts to light.
23 T,W.	32	Private	1st Hants	Bullet entered left eye, passing horizontally through the bridge of nose behind the right eye. The exit wound being one inch and a half behind external angular process on right side.	La Bassée 2/2/1915	Doubtful P.L.	Smell not affected. Both eyes shrunken. Was under Mr. Jessop in No. 1 Base Hospital
24 L.	31	Drummer	West Yorks	Bullet entered on the left side at level of apex of orbit and passed obliquely forward through right orbit.	At the Aisne 20/9/1914	Bare P.L.	Was under Dr. Clegg of Manchester. Right eye removed in France. Left eye in situ. Pupil reacts, optic disc white. Extensive pigmentary changes at macular. Rupture of choroid and retina.
25 G.D.	26	Private	2nd Dorsets	Bullet entered on left side below orbit and passed obliquely upwards and outwards.	Basra, Persian Gulf 17/9/1914	Right eye sees shadows and contrasts in lower part of field.	Both eyes in situ. Right eye, white mass of organised blood covering over the optic disc, otherwise media are clear. Left eye, vitreous chember full of organised blood clot.
26 E.C.	31	Private	King's Own Yorkshire Light Infantry	Bullet entered the right side of head above the brow and passed through to the left ext. angular process.	Ypres 21/12/1914	No P.L.	Both eyes were destroyed. Ptosis of left lid, Smell not affected.
27 N.P.	23	Lance-Corporal	1st King's Rifles	Bullet entered near malar bone on left side and traversed apices of orbits, leaving close to right external angular process.	Aisne 19/9/1914	Left eye can tell the time by a watch. Right eye blind.	Both eyes in situ. Right pupil dilated and fixed, but reacts consensually. Rupture of choroid at posterior pole with large mass of organised blood clot coming forward into vitreous Left eye. fan-shaped rupture of choroid below and on outer side of optic disc. Has a paracentral scotoma, sees best on outer side.
28 F.H.	32	Private	2nd Welsh	Was sniping and using field-glasses which he thinks heliographed his position, as he was shot by bullet which came through loophole and struck the glasses, driving fragments of metal into both eyes and nose.	Neuve Chapelle 1/4/1915	Counts fingers at one foot with right eye.	Large hole in nose going through to the nasal cavities. Right eye in situ. Pupil widely dilated but reacts slightly. Vitreous full of blood. No details of fundus visible. Left eye deeply scarred and shrunken.
29 M.	40	Corporal	1st Duke of Cornwall's	Was blown up by a "booby" trap.	Neuve L'Eglise 11/3/15	Nil.	Both eyes destroyed. Extensive wound of face.
30 F.	25	Private	2nd Devons	Orbits transfixed by bullet.	Neuve Chapelle	Nil.	Both eyes destroyed.

Letters from Men on Active Service.

DEAR MR. EDITOR,

My GAZETTE has been regularly forwarded to me since I arrived in France at the beginning of December last, and I see that you have been well supplied with news by correspondents serving with almost every kind of unit. Since, however, I have the privilege of being attached to a new and original type of hospital, I thought a short account of our work might interest you.

After three of the muddiest and most depressing months of my existence spent at Havre as M.O. to a large rest and reinforcement camp, where my duties consisted of "morning-sick," inspection of drafts, and inoculations, I was very much rejoiced at getting transferred to the Malassies Hospital, B.E.F. You will very probably have read a lengthy account of the place in the B.M.J. It was primarily a hospital for Belgian Refugees suffering from typhoid fever. Its object was military first of all, the aim being to clear the fighting zone of infective non-combatants and to see that none returned as "carriers." Incidentally, of course, it is also humanitarian in its achievement, and an institution for research.

The hospital consists of a large monastery, which has numerous long dormitories that have been converted into first-class wards, and a surrounding encampment. The wards have been reserved, as far as possible for the women and children, while the camp is for the male acute cases—most of whom have come under me latterly—and for convalescents.

The whole place is admirably organised, and we have a large nursing staff. There is a laboratory with two excellent bacteriologists, so that diagnoses can be really accomplished, and good work done in the realm of vaccine therapy. All fatal cases are investigated post-mortem. So, you see, our opportunities of acquiring knowledge of typhoid are all that could be desired. I have learnt a great deal and thoroughly enjoy the work. Latterly the place has been extended in its scope, and we have had other infectious cases to deal with. We are also prepared to take in some wounded if necessary.

We have here Lt.-Col. Pollock, who, you may remember, opened the Physical Society's discussion on the "Treatment of Syphilis" about two years ago. D. W. John and H. L. S. Griffiths and a Sister from Guy's are also here, so the hospital is well represented. Football and minstrelsy have been the principal recreations. John's rendering of "The Spaniard who blighted my Life" has been as well sung and as vociferously applauded in the basement of our monastery as ever it was at Christmas festivities at Guy's.

I have recently seen Marshall, Billing, Reynell, Starling, and John Watkin, and Frank Cook paid a flying visit a short time ago.

Flemish is not an easy tongue, and only a small percentage of the patients speak French. One has realised more fully than ever, as the result of the language difficulty, the preponderant importance of history and symptoms as contributory factors to a diagnosis.

We are within sound of the guns, but otherwise there is very little in our peaceful agricultural surroundings to suggest active warfare.

Yours sincerely,

JOHN RYLE.

University of London Officers' Training Corps.

Medical Secton.

APRIL CAMP.

AFTER a period of relative inactivity during the winter months, a condensed course has been organised in order to afford to those, who will shortly be qualified, an opportunity of acquiring some knowledge of R.A.M.C. field work, and of taking the examinations for A and B certificates. It was originally intended to hold a week's camp at Easter, but, as that date clashed with examinations, it was postponed till April 19th to 26th. The camp was held in meadows attached to Arkley View, Arkley, under the command of Major A. M. Gray, and was quite a success in spite of the absence of many of the senior men. The nights were still cold for sleeping under canvas, but the ground was dry, and there were no ill effects beyond occasional sore feet. No small part of the success is to be attributed to the catering by the Quartermaster, Lieutenant Cleminson, and the cooking by Corporal Coombs, of Guy's, and his squad. The latter was somewhat of an experiment, as, except for week end camps, it has been usual previously to employ professional cooks, and the cooks' squad is to be congratulated both on their public spirit and their efficiency,

The work of the camp, which began with reveille at 5.30 a.m., consisted of squad drill, stretcher drill under various conditions, field ambulance drill, tent pitching, sanitary work, demonstrations of equipment, the formation of dressing stations and the work of a tent sub-division, route marches, and, finally, a night operation. This consisted in bringing in wounded on stretchers from three abandoned regimental aid posts under observation of the enemy's outposts. One of the aid posts was at the end of a muddy lane, the others across fields to east and west of the lane and designated by compass bearings and distance. Unfortunately it was a clear moonlight night, so that it was easy to find one's way, but difficult to escape observation.

The camp was inspected by Colonel Tooth on the 22nd and by Colonel Capper on Sunday, the 25th, and was visited on the 22nd by Major Layton with a motor ambulance. The next camp will be held from Friday the 21st May till the following Tuesday.

Syphilis of the Cardio-Vascular System.

CLINICAL LECTURE BY HERBERT FRENCH, M.A., M.D., F.R.C.P.

Gentlemen,—The case which suggested to-day's lecture was one which many of you saw in the post-mortem room last week. He was a man of 43 who, apparently in the best of health up to that moment, and a hard physical worker, suddenly fell dead. At our post-mortem examination we found the cause of death to be a hæmo-pericardium, the cause of the latter being sudden rupture of a minute aortic aneurysm situated just above the aortic semi-lunar valves, and therefore in that part of the aorta which lies within the pericardium. From this plate specimen which I will pass round for you to examine you will see that the heart as a whole is of normal size; the valves are healthy except that there is some thickening and deformity of the aortic valves from syphilitic atheroma, as yet insufficient in degree to have led to either regurgitation or stenosis at the aortic orifice, but immediately above these valves and for one and a half inches beyond them the wall of the aorta is irregularly thickened, boggy, and soft as the result of acute syphilitic atheroma. There is an almost sudden cessation of this atheroma at the beginning of the transverse arch, and the arch itself, the descending thoracic and the abdominal parts of the aorta are perfectly healthy. This distribution of syphilitic atheroma of the aorta is characteristic; whereas senile and alcoholic atheromatous changes may affect the whole of the vessel indiscriminately—the abdominal part as much as any other—syphilitic atheroma tends to affect the part nearest to the aortic valves very much more than the parts further on, and one often finds the first few inches of the aorta very much diseased from syphilis and the remainder practically healthy, as is the case here.

If, now, you will look carefully at the heart again, you will see a small hole in the midst of the atheroma, a quarter of an inch above the valves, and this hole leads into a small very thin-walled saccular aneurysm, which is barely large enough to contain the terminal joint of one's index finger, and which projects to the right within the pericardium, in front of the right auricle. There is a split in the dome of this minute aneurysm, and a glass rod has been placed through the rupture. It was the bursting of this little saccular aneurysm into the pericardium which killed the patient suddenly. It was not the actual amount of blood lost that mattered so much as the fact that this blood had all the aortic blood pressure behind it; so that the outside of the heart was suddenly compressed by this blood under a pressure much greater than that which normally exists within the auricles; the latter having a greater pressure outside them than within them, the circulation was stopped as effectually as if one had tied a strong ligature suddenly tight round both auricles.

You will be certain to meet with such a case as this sooner or later in practice for it is of a well-known and not uncommon type. Sometimes the patient will be known to have had an aneurysm because of symptoms, but sometimes he may have seemed to be in perfect health. In this particular instance, for example, the man might well have been passed for life insurance the day before his death; for the aneurysm was so small that it could produce no pressure symptoms, and indeed it would not have been visible even at an x-ray examination. The other viscera were all healthy, but in confirmation of the diagnosis one found multiple pigmented scars over the soft parts of both his legs, the result of healing of former syphilitic ulcers, and also a well marked scar upon the glans penis a little to the right of the frœnum.

There are other ways in which syphilis may cause sudden death, but these we will leave to a later part of this lecture, or perhaps to a second lecture.

Syphilis of the Cardio-Vascular System.

The subject of syphilis of the cardio-vascular system may be sub-divided into two well-defined parts, both clinically and pathologically. These are:—

1. Syphilis of the arteries.
2. Syphilis of the heart.

You may ask: but what about syphilis of the capillaries and syphilis of the veins? There is no reason why syphilis should not affect veins and capillaries as well as arteries, but so far as practice is concerned syphilis of the veins and syphilis of capillaries may be left entirely out of court. Let us consider in the first place syphilitic affections of arteries.

I.—Syphilis of Arteries.

Syphilis affects arteries in two main and distinct ways, termed respectively: (1) Endarteritis obliterans and (2) syphilitic atheroma. I suppose that any arteries in the body may be affected by either of these processes, but for

practical purposes one may say that endarteritis obliterans confines its incidence mainly to the cerebral and the spinal arteries, whilst syphilitic atheroma, though it may also affect the coronary arteries severely, is in the main an affection of the aortic valves and aorta, especially that part of the aorta which is nearest to the heart as has been described above.

I have found that there is a good deal of unclear thinking amongst students and others as to what is taking place in arteries that are the subject of one or other of their four commoner affections, namely—

1. Atheroma.
2. Arterio-sclerosis.
3. Endarteritis obliterans.
4. Senile calcification.

And many men speak of arterio-sclerosis and of atheroma, for instance, or of senile calcification and arterio-sclerosis, as if they were interchangeable terms. This is perhaps due to the fact that arterio-sclerosis and atheroma and senile calcification, or syphilitic atheroma and endarteritis obliterans, may be present at the same time in the same person; but it is of practical use to distinguish clearly between the essential changes in each of the four lesions. We discussed this question at some length together at Out-Patients only last Friday, but I will run briefly over the chief points of distinction again now, with the help of the following diagrams:—

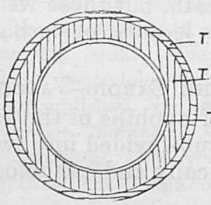


FIG 1.

DIAGRAM OF CROSS SECTION OF A NORMAL ARTERY.
T.I. = Tunica Intima. T.M. = Tunica Media.
T.A. = Tunica Adventitia.

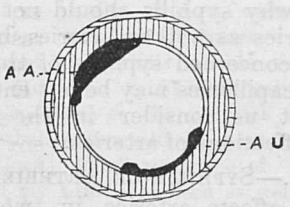


FIG. 2.

DIAGRAM OF ATHEROMA: a local affection of Tunica Intima.
A.A. = Atheromatous Abscess.
A.U. = Atheromatous Ulcer.

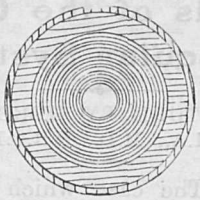


FIG 3.

DIAGRAM OF ENDARTERITIS OBLITERANS: Concentric proliferation of Tunica Intima.

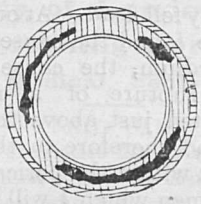
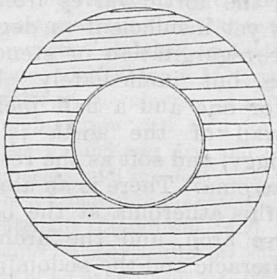


FIG. 4.

SENILE CALCIFICATION: "Pipe-stem" Artery. Calcareous deposits in Tunica Media.



FIG· 5.

DIAGRAM OF ARTERIOSCLEROSIS: Fibrosis of Tunica Media; thickening and fusion of Tunica Media and Adventitia. Lumen looks less than that of Figs. 1, 2, or 4. but is in fact the same. An optical illusion.

You will remember that the arterial wall consists of three main coats. There is the inner lining membrane, consisting of little more than flat endothelial cells upon an elastic-tissue base —the *tunica intima*. Around this is a relatively thick coat consisting mainly of non-striped muscle tissue, with much elastic tissue and a little fine fibrous tissue—the *tunica media*. Outside this is a supporting external coat, partly elastic, but mainly composed of fibrous tissue—the *tunica adventitia*.

Senile calcification.—Of the four commoner affections of arteries let us think in the first place of the least important, namely senile calcification. This has nothing to do with syphilis at all. In old men of 70 or more, when you feel the radial pulse you often get a sensa-

tion of shot or of little particles of grit under the skin in the course of the radial artery. This is the result of irregular depositions of lime salts in the middle coat of the vessel, and it has nothing to do, at any rate essentially, with either atheroma or with arteriosclerosis. It is true that, owing to the patient's age, there is very likely atheroma in his aorta, or cerebral or coronary arteries at the same time, but the senile calcification of the radials is not itself either atheroma or arteriosclerosis; and indeed it is quite common to find extremely calcareous radial arteries and yet no extreme degree of either atheroma or arteriosclerosis elsewhere at all; the patient may be relatively hale. You will often find old people with even "pipe-stem" radial arteries in the enjoyment of good health for the age. When one hears people say of such a calcified radial artery: "good gracious, what an atheromatous radial artery; this man must have a high blood pressure!" one knows that the person making this remark has an entire misconception of the nature of the various pathological changes that affect arteries. Many persons with calcified radials have an almost normal blood-pressure, and there is no reason at all why the calcification should imply any arteriosclerosis whatever. The deposition of lime salts in the radial artery is a purely senile change, comparable to calcification of the rib cartilages, or of the cartilages of the larynx, or to the development of senile cataract. Although it may be associated with atheroma or with arteriosclerosis, or with both, it is distinct from either, and may occur without either.

Arteriosclerosis.—Arteriosclerosis has not been shown to be due to syphilis; and therefore although it is a very important condition indeed I cannot discuss it to-day beyond saying that it is one of the most important causes of high blood pressure; that it is essentially a disease of the middle coat which becomes very fibrosed, thick and inelastic from conversion of the muscle cells into fibrous tissue (see figure above); and that it is quite distinct from atheroma in which the essential changes start in the tunica intima.

Atheroma.—Atheroma, sometimes due to age alone, often accentuated by alcohol or hard physical strain, sometimes brought on at a much younger age by syphilis, affects the aorta in particular, in the way described above, though it may involve almost any artery in the body besides, especially the coronary arteries and the cerebral arteries. In all of them the lesions are similar, and start primarily in the tunica intima; they are focal changes—that is to say they do not involve the inner coat equally all the way round but occur in patches. There is focal proliferation of the deeper layers of the tunica intima leading to the formation of patches which, in the post-mortem room, are raised, irregular, and yellow. Many healthy young persons have irregular yellow streaks on the tunica intima of the aorta, almost indistinguishable from the earliest changes of atheroma though they cannot be called by that name; and it is very difficult to say just when these patches cease to be normal and first merit the term atheroma. When this latter disease has become more definite, however, one has no doubts.

The focal proliferation of the deeper cells of the tunica intima causes a series of raised yellow patches; sooner or later the deeper layers soften and one gets the condition spoken of as an atheromatous "abscess" though there is no pus. Later on the blood-flow over this softened patch strips off its surface, the softened deeper parts are carried away and one gets an irregular depressed patch, no longer covered by endothelial cells, and spoken of as an atheromatous "ulcer." There is often some deposition of lime salts in the base of such an ulcer, and the aorta crackles like egg-shell when it is being cut open with the scissors. Although the primary changes are in the tunica intima, the changes in the latter act as an irritant to the adjacent tunica media which becomes infiltrated focally with small round cells, and thus softened; and it is by an extension of this softening process, which is particularly marked in syphilitic cases, that the whole wall bulges under the pressure of the blood within the artery and an *aneurysmal dilatation* is apt to result. By far the commonest cause of all aortic aneurysms is syphilitic atheroma.

Endarteritis obliterans.—Endarteritis obliterans is essentially syphilitic in origin, though there may be other factors, such as enteric or some other specific fever, in exceptional cases. The changes that result in the vessel are entirely distinct from those of any of the three we have just discussed. Endarteritis obliterans does not affect the aorta or the big vessels; its incidence falls almost entirely upon the cerebral and spinal arteries, though it may also affect the coronary arteries. It is endarteritis obliterans that is the main cause of syphilitic hemiplegia and of syphilitic paraplegia.

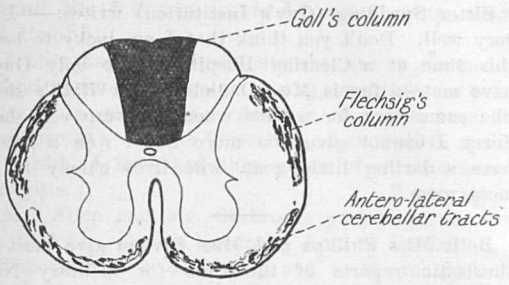
The essential changes in the affected vessels are in the *tunica intima*, but instead of affecting the latter focally as atheroma does, they involve this coat all round the inside of the artery,

producing a concentric proliferation of the endothelial cells until the latter may be twenty or thirty layers deep; the lumen of the artery is thereby reduced, sometimes to an extreme degree; one might compare the result to that which takes place in hot water pipes that are getting choked up with furr. The parts which the affected artery supplies obtain a progressively less and less efficient blood supply through the furred up vessel; a time comes when this supply is less than the minimum requirements, and then impairment of function—cerebral softening for instance—results. Often, in addition to the gradual "furring up," clotting of blood occurs in the stenosed artery, and the symptoms of ineffective circulation come on almost suddenly instead of slowly. I show you here a specimen of a brain with endarteritis obliterans of the right middle cerebral artery, thrombosis within that vessel, and softening of the parts in and around the right internal capsule—all the indirect result of syphilis; and under this microscope you will see a good example of a transverse section of a cerebral artery affected by endarteritis obliterans without thrombosis.

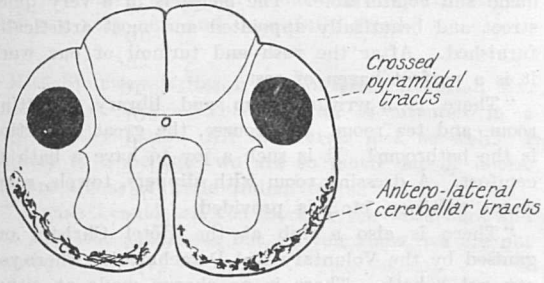
What would be the clinical symptoms in a case of syphilitic endarteritis obliterans? There may be no symptoms, even when the condition is advanced. But if it is of more than a certain degree of severity there must be an ineffectual blood supply to the parts beyond. If several cerebral vessels are affected at the same time, there will be more or less cerebral softening, and the patient will exhibit mental symptoms of various kinds, often amounting to actual insanity or complete dementia. If the middle cerebral artery is the one most affected, there will be softening of the internal capsule—that is, there will be hemiplegia on the other side. In men between 20 and 35 years of age the commonest cause of hemiplegia is syphilis causing endarteritis obliterans of the middle cerebral artery. The onset of the symptoms generally differs from that in hemiplegia the result of hæmorrhage, in being rather less sudden; in the former it is a case of touch-and-go, in the first place, as to whether there is just enough blood supply or not. The patient may wake up one morning and feel his arm weak, but he may not take much notice of it, and even go to work. Later in the day, or perhaps not until next morning, the arm feels weaker, and perhaps a little weakness is also noticed in the leg of the same side. This may all pass off again, or, especially if thrombosis has supervened on the endarteritis obliterans, the paresis passes quickly on to paralysis, and the latter may persist. There is seldom any sudden loss of consciousness at the onset of syphilitic hemiplegia, as there so often is where the paralysis is due to cerebral hæmorrhage.

The other arteries liable to be involved by endarteritis obliterans are the spinal arteries. If you remember the distribution of the blood to the spinal cord, you will have a clear idea what the symptoms are like. (Drawing on blackboard.)

There is a very free inosculation between the many arteries that run up and down the outside of the cord so that any quantity of collateral circulation is possible previous to the entry of a spinal artery into the cord itself; the series of arteries in the anterior fissures send branches into the spinal substance at very short intervals but each such branch, once it has entered the cord, has practically no collateral circulation, for each is an "end artery" for the supply of its own particular cross section. One might compare the spinal cord in this respect to a long column of coins piled vertically one above the other, each coin representing the part supplied by a single spinal end-artery. If there is endarteritis obliterans in the latter, followed by thrombosis, there will be acute softening of the parts supplied by that artery—one of the discs in the column of coins completely destroyed. A transverse disc of cord, of no great vertical height, will be as it were wiped out so as to dissociate the lower from the upper part of the spinal cord nearly as completely as if the cord has been cut across with a knife. The condition is generally spoken of as one of syphilitic transverse "myelitis"; but this is a misnomer, for there is no "itis" in the sense of inflammation; it is simply a transverse softening, the result of thrombosis, exactly comparable to the similar changes in the brain that lead to syphilitic hemiplegia The resultant changes in the cord are shown by these two microscope sections taken from an actual case and stained by Marchi's method. I will pass them round for you can see the degenerated tracts without the microscope if you hold the slides a little way off from a piece of white paper. The syphilitic endarteritis obliterans and consequent softening were in the mid-dorsal region. In the section taken from the lower dorsal region below the level of softening, you will see degeneration in the crossed pyramidal tracts and in the antero-lateral cerebellar tracts, the rest remaining healthy; in the other section taken from the cervical region well above the transverse softening you will see de-



Tracts degenerated in the section taken high above the level of the transverse softening.



Tracts degenerated in the section taken below the transverse softening.

generation in Flechsig's direct cerebellar tracts, in the antero-lateral cerebellar tracts and in the whole of Goll's columns; Burdach's postero-external column is not degenerated in this section; it would have been in one taken close above the site of transverse softening, but the particular section was taken a good deal higher up, the fibres that were in Burdach's column in the dorsal region have passed in to Goll's column, and fresh fibres entering the cord from the arms have come in to fill Burdach's column, and these are not degenerated.

The clinical results affect the legs chiefly. There will be paraplegia of the spastic type, and if it is complete there will be anæsthesia as well as inability to move the legs. If less complete, the anæsthesia will be less marked than the paresis. The knee-jerks will be exaggerated, the plantar reflexes of the extensor type, there will be ankle clonus, and at some stage or other the bladder and rectal sphincters are liable to be affected.

The condition is very similar in most respects to the spastic paraplegia that results from compression of the cord by spinal caries or new growth, but there is one very important point of distinction between this paraplegia of syphilitic origin on the one hand and compression paraplegia on the other, and that is the incidence of *pain*. There is no pain when the cord itself is irritated provided the posterior nerve roots are not involved. Compression always involves the posterior nerve roots as well as the cord, and pain is experienced and complained of by the patient, at least at the beginning. The syphilitic lesion involves the cord but not the posterior nerve roots, and pain is in most cases conspicuous by its absence.

You would think that in such a case the patient would have premonitory symptoms before he got complete paraplegia. Often he does; there may have been a transient paresis days or weeks before the more complete paralysis. But what is very remarkable in many of the cases I have seen is the suddenness with which the symptoms often come on, and how often they are determined by an accident. A man is kicked in the back by a horse, and he cannot use his legs any more, and it looks as if the kick were responsible for his paralysis; but in many cases there has really been a condition of almost minimum blood supply through an artery which has been partly furred up by disease, and the injury has been enough to bring into objective evidence the long-standing syphilitic disease of the vessel, often perhaps by leading to thrombosis in the already diseased artery. I mention this particularly because some of you will find some day how important knowledge of this may be when it is necessary to consider cases of this sort from the point of view of employers' liability, and compensation for accident.

(To be continued.)

Change of Address.

D. C. Lloyd, West Wales Sanatorium, Llanybyther, Carmarthenshire.

Surg. F. G. Lloyd, R.N., from H.M.S. *Victorian*, to R.M.A. Barracks, Eastney, for Howitzer Brigade, Expeditionary Force.

2nd Lieut. J. N. Martin, Army Service Corps, B.A.P.O. No. 2, British Expeditionary Force.

Lieut. G. E. Lockyer, R.A.M.C., Military Hospital, Sutton Veney.

Lieut. G. S. Miller, R.A.M.C., Cambridge Hospital, Aldershot.

Capt. G. H. Hunt, R.A.M.C.(T.), 2nd London Casualty Clearing Station, 1st Army, British Expeditionary Force, c/o G.P.O.

Lieut. W. R. Ransford, from Rangoon, to 1st Batt. 10th Gurkha Rifles, Maymyo, Upper Burma.

E. P. Poulton, M.A., M.D., B.Ch., M.R.C.P., Vergemount, Woldingham, Surrey; *Tel.* 61 Woldingham (Country address).

Nursing News.

Matron's Office,
18th May, 1915.

The response to Matron's request for information as to the doings and whereabouts of all Guy's nurses working for sick or wounded soldiers and sailors at home or abroad has been good, but many of the post cards have not been returned. All correspondents are assured that news is very welcome, and letters written, as we know, in the very precious off-duty time, are received with great pleasure.

So many of our correspondents say what a great delight it is to read of the doings of friends and how eagerly they look forward to the Gazette, and yet beg that their own contributions shall not be published!

The Institution was prepared to give a great welcome to Miss Ames, as she was expecting leave on Miss Kiddle's return, but, writing on the 1st of May from a Clearing Station, she says: "For the last four or five nights we have taken in without stopping about 300 a night, and every case had to be dressed. Of course, leave is out of the question. Sister Kiddle came back last night, but she is being sent to Boulogne, and we are very sorry to lose her. It is getting quite hot, and the weather is very beautiful."

Sisters Savage and Maddison are stationed at No. 13 General Hospital, Boulogne.

From Arc-en-Barrois, Haute Marne, Miss Gibson writes, "This is a lovely part of France, and flowers growing in abundance. Sir Claude McDonald came to lunch the other day and said we might at any time be required to return to England to nurse our own men, and he hoped every nurse would feel it her duty to do so."

From No. 4 General Hospital we hear, "Ten sisters have lately been moved—Misses Hepburne and Bourdillion to No. 18, Miss Robinson to No. 13 Stationary, so the number of Guy's here is reduced to three. The country round here is looking beautiful, with a lovely moon, and nightingales serenading us; so different to Maze Pond on night duty. Mr. Jepson has just joined this hospital."

From No. 6 General Hospital, April 17th, Miss Quilter writes, "I have four huts to look after, with an orderly, 31 beds in each hut. We moved out of our tents into the huts about a month ago, and are only just beginning to get used to them. They felt so stuffy at first. They are much lighter than the tents and the nursing is easier in consequence, but we were loth to leave our tents, all the same."

Sister Spedding (Guy's Institution) writes:—"I am very well. Don't you think that I am lucky to be all this time at a Clearing Hospital. The only Guy I have met so far is Miss Daniels, Sister Ruth's sister. She came here for a time when we were very busy. Sorry I cannot give you more news. As a pet we have a darling little goat, who lives chiefly in our mess room."

Both Miss Phillips and Miss Savage give most enthusiastic reports of the Club for Military Nursing Sisters at Boulogne: "Mrs. Eustace Robertson is simply charming and makes everyone feel at home and comfortable. The house is in a very quiet street and beautifully appointed and most artistically furnished. After the rush and turmoil of our work it is a perfect haven of rest.

"There is a writing room and library, a sitting room, and tea room. Of course, the great attraction is the bathroom! It is such a joy to have a bath in comfort. A dressing room with slippers, towels, soap, water softener, etc., is provided.

"There is also a club at the Hôtel Christol organised by the Voluntary Aid Detachment. There you can get a bath. There is no charge made at either club, except a small charge for tea at the Hôtel Christol. At Mrs. Eustace Robertson's house everything is free. I cannot say more than that it is just a very well appointed English home, and just now we all feel that an English home will be a greatly appreciated place when the war is over."

On May 12th the Misses Strutt, Mackenzie, and King left Guy's Hospital for France, and wrote on May 13th to say they had arrived safely after a good crossing. They were delighted to be all stationed together at No. 18. "The first person we met was Sister Kiddle; she looked very well. To-day is very wet, so it is a case of gum boots straight away."

On May 2nd, Miss Tyers writes from Aldershot:—"Orders received to leave for Egypt this week—destination unknown. We are taking camp kit, so expect to be under canvas."

From the Rawal Pindi British General Hospital, Miss Squire and Miss Roussiano, writing on May 7th, say, "They have had many cases of gas poisoning, some very bad. They are treated as acute bronchitis or heart cases. The weather is delightful now. We were very pleased when Mr. Seabrooke joined this hospital."

April 27th, Miss Hiles, writing from Rouen, says:—"There are a large number of Guy's nurses here. I often see Misses Foxon, Tyler-Cove, and Tyndale. Sisters Masters and Leggoe are at No. 2 Officers' Hospital in the town. Sister Daniels expects daily to be

sent to a Clearing Hospital for a few weeks. I believe all No. 6 Sisters are to be sent in turn, three at a time.

"I have had several patients who live in Bermondsey, and one man recognised me as his wife's nurse in 'Mary' two years ago. Another man had been in Sister Brown's ward at Versailles. I am still in medical wards. I have had three cases of cerebro-spinal meningitis.

"Mr. Allen met Mr. Seabrooke yesterday, and we hear that Mr. Sherris has lately been in Rouen.

"The weather is delightful, and tents are ideal to work in for the summer. We have both sides rolled up, and the men thoroughly enjoy lying in the sun. You will have heard all about the hospital barges; they are very nice and beautifully fitted."

Miss Spurway writes from Malassies Hospital, Ex. Force, May 2nd:—"This hospital is situated in a very healthy place. All the nurses look so well. I suppose it is because we are so much out of doors. We are living in little Indian tents.

"I wish I could tell you more of the work here and also send the snapshots, but, as you know, we are not allowed."

Miss Daniels, in writing (May 4th) to Matron and Sister Looker to thank them for making and sending bags to hold the patients' personal property, says:—"The bags are most useful; you can imagine with open lockers, and not always one to each patient, how untidy they look, and the orderlies are only here such a short time it is difficult to get them to look after such things.

"I have two wards of 31 beds each, one staff nurse, and three orderlies to help. It has been very hard work the last ten days, the patients have been coming in so quickly.

"I was told that my name was down with two others to go to a Clearing Hospital for a time, but have not yet been called up. I should like the experience, but just now feel there is plenty to do here.

"Last Monday Miss McAra and Miss Quilter went to No. 18 General, and only Miss Warner and Miss Nelson beside myself are left of the party I came out with.

"The weather has suddenly turned very hot. It was nearly 80° to-day in my room, and after the terrible cold the change is great, but in spite of all I am very well and happy.

"Please remember me to all Guy's friends, and please tell them that I get little time for writing letters, but we do like to receive them."

Miss Mann (Guy's Institution), writing from No. 1 General Hospital, April 24th, says:—"Misses Finnis, Prince, and Banbury have left us. Misses Owens, Sharwood, and Waters are still here. From Christmas until now the work has varied, quieter intervals, and then very busy with the arrival of a convoy."

Miss Lucy Cornwall, who went out at the end of April with Miss Hilliard, writes:—"I am allowed to say that this hospital, No. 8 Stationary, is under canvas about two and a half miles out of Boulogne.

"Sister Hilliard and I were sharing a bell tent as a bedroom at first, but now I am on night duty."

Miss Cornwall also mentions the club in Boulogne and the "luxury" of a bath.

"Washing is done in the tents under difficulties, as all the water we want has to be heated on the little oil stoves."

Writing from Boulogne, May 12th, Miss Colston says:—"I am still here, the Cassino, where I was first drafted in October. I am now made Acting Sister in Charge of my ward. Misses Maddison, Savage and Roach are now here to represent Guy's as well, and Sister Wilson who was transferred from train duty last week.

"You will see from the newspapers how busy we have been, for although we are a base hospital, we have taken in patients at 10 a.m. and sent them on again at 12 washed, fed, and re-dressed. Boulogne must be very healthy for we all keep wonderfully fit in spite of the very hard work. I have never worked so hard before.

"I wish I could give you the numbers of our 'take-ins' per day. The staff is so small in comparison, but I expect that you know the number of nurses allowed to a General Hospital. We all dream of leave, but I don't know if our dreams will ever be realised."

Miss Dottridge, writing (May 3rd) from an Urgency Cases Hospital, in France, says:—"I came out with this hospital as Night Superintendent. We are in new and grim barracks, and so far do not get a glint of sunshine, but when it is hot we shall rejoice in the shade. One reads a good deal about help being wanted in French hospitals, but they do not keep our beds filled, and many of the cases would be treated in Out-Patients at Guy's.

"The country here is glorious, but there is a good deal of sickness amongst the staff. Also a tremendous number of typhoids in the town; when first we came the deaths averaged 28 per day, and in the cemetery near here 3,600 have already been buried.

"We have six surgeons and a radiographer, and our own ambulance, and really good equipment, short only of sheets. Fortunately there is a bath place near, with lovely baths for one franc.

"The food is improving; at first it was awful. We brought out four girls to do the cooking, and I think that they had been taught in schools, for they had no idea how to buy for a place like this."

The following Institution Nurses are now working for the wounded at home (in addition to ten names previously given):—Miss McMahon, Sister-in-Charge, V.A.D. Hospital, Wellingborough. Miss Sherrard, at Milton House Hospital, Peterborough. Misses Greaves, Sawyer, and Gerrard, at the Bevan Military Hospital, Sandgate, Kent.

A Case of Complete Absence of Vagina and Uterus.

Reprinted from the *South African Medical Record.*

BY X. Y. Z.

As total absence of vagina as well as uterus is said to be extremely rare, I am venturing to report the following case, and most urgently request that any readers will offer advice as to treatment. S. M. is a girl aged 23. Height 6 feet 1 inch. All organs appear to be perfectly healthy, but there is marked acne of the face and back, and the hands and feet are generally cold and clammy.

I was first consulted by her some five years ago for amenorrhœa. Various remedies were tried. She was not seen frequently, but as no improvement was noted, an examination was advised. An anæsthetic was administered in the surgery by a colleague. Examination was made digitally. An orifice was found which admitted the first finger with a slight amount of pressure. No sign of an os uteri could be found, and it was then realised that the finger was not in the vagina, but the bladder. The patient subsequently had a fair amount of pain and incontinence of urine. About two months later she consented to go to hospital for a plastic operation.

At this operation a most thorough examination was made. The external genitalia were normal in every way. The mons veneris, labia majora and minora were normal, but there was complete absence of the vagina. *There was no sign of any urethra—i.e.*, the bladder appeared to be normal—but the exit occurred at the front of the perineum without any indication of a constricted passage, such as would be expected from a normal urethra. The condition of the bladder may be compared to a tennis ball with a hole in it.

I am laying emphasis on this fact because medical men to whom I have spoken appear to doubt the complete absence of any urethra.

The "hole" was repaired and united well, but as incontinence of urine was still present, subsequent operation was undertaken to close the orifice to the size of a No. 6 catheter. Contrary to expectations, the repair was again unsuccessful, and the patient complained of inability to pass urine, and a condition of moderate retention ensued. Nothing further was done, and this condition lasted for about three months—not, however, with retention when the patient walked about, but with incontinence. Examination at the present time shows that part of the repairing tissue has given way, and there are two "holes," both about the size of No. 12 catheter, and between these "holes" a narrow septum.

The condition of the patient is piteous. There is no control whatever over the urine, so that the garments are always soaked. I have asked surgical instrument makers for any appliance likely to be effective, but cannot receive any encouragement. Sponges cannot be properly applied; absorbent diapers appear to be useless. I appeal to my readers to offer suggestions, and request that anyone who has had any case similar will do so.

As regards the presence of ovaries, I am not prepared to swear to their absence or presence, Bi-manually, it was thought that the left ovary could be felt. No thickening to represent a rudimentary uterus was noted.

It is of interest to record that periodically, but not at any very definite intervals, complaint is made of pain in the region of the bladder, and in fact of the entire pelvic girdle.

The patient is to some extent hysterical, and the urine has on occasions shown a specific gravity of 1004, but is in other respects healthy and acid. Occasionally there is intense pain and symptoms of cystitis.

[X. Y. Z. is an old Guy's man.—ED. G. H. G.]

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

DEAR SIR,—Relative to my correspondence in your issue of February 27th, I beg to forward you a letter from Dr. C. Pearson, which tends to throw some light on the subject therein treated, and may be of some interest to your readers.—I am, dear Sir, faithfully yours,

Monkhof. Sabie. W. H. DIXON.
April 21, 1915.

DEAR DR. DIXON,—I have seen your letter in the February 27th issue of the GAZETTE. The grubs which you describe are no doubt the larval forms of flies of the genus Cordylobia. These are yellow in colour in body and wing, but the different species vary in details.

If you examine carefully you will find minute spines, recurved, along a number of the middle segments, and mouth hooklets on the inner side of the antennæ on the ventral surface.

These pests are fairly widely spread throughout Rhodesia, and we meet them occasionally in the Congo. It is not known whether the fly lays the eggs on the clothing or the skin. From the number of cases where one meets the larva in the scrotum one supposes that it may lay its egg there directly during defæcation: or it may choose those garments when hanging out to dry after the wash. Your treatment is the only one which I know and always cures them. The larva must be squeezed out as soon as the diagnosis is made.

You will probably have had an explanation from elsewhere before I could write to the GAZETTE. If not, perhaps it might be of interest to them for you to send them a note of this. This frequently affects dogs also.—Yours sincerely,

ARTHUR PEARSON.

Elisabethville-Fonderie,
Katanga, Congo Belge,
April 9th, 1915.

DEAR SIR,—I was interested in what I read in the current issue of the GAZETTE about carrot poultices. Before entering Guy's, as a pupil at a county hospital, I frequently had the opportunity of seeing them applied to old fetid ulcers and foul suppurating wounds. They were used to supplement the charcoal poultice, and I can answer for it they did what was expected of them, but not, I think, if my memory serves me, quite so satisfactorily as the Cataplasma Carbonis.—Faithfully yours, 1873.

92, Beaconsfield Road,
Preston Park, Brighton,
May, 16th, 1915.

"Britain will not let Belgium Starve."

SIR,—We have pledged our honour to restore Belgium. But Belgium is not a word—it is a people; and the Belgian people is starving. If we let it perish during the process of restoration we shall have grasped only the shadow of our task.

Mr. Hoover, Chairman of the neutral Commission for Relief in Belgium, and Mr. Francqui, Chairman of the Committee in Brussels, tell us that "at least a million and a half Belgians are now entirely destitute. With the rapid exhaustion of the meat and vegetable supplies, there will probably be, before harvest time, 2,500,000 Belgians who must be fed and clothed solely by charity. The remaining 4,500,000 will get their pitiful daily allowance of bread through the Commission and will pay for it." And they add: "Will you help us to keep the destitute alive?"

This neutral Commission, marvellously organised and administered, has hitherto succeeded in just keeping abreast of the situation, raising its funds from America, other neutral countries, and the British Colonies. But their funds are failing fast; and their needs are getting greater. It is in response to their desperate appeal that a National Committee for Belgian Relief has now been formed in our country, and every penny it collects will go without deduction into the hands of the neutral Commission, and through them to the starving Belgian people, in the form of food. So far Germany has kept her word not to filch what is sent for the Belgians: and the organisation of relief now makes it almost impossible for a German to touch one loaf of Belgian bread. The present need is for £500,000 a month; the future need will be even greater.

Our own exigencies are, of course, tremendous; but what would they not be if Belgium had consulted her own material needs, had just chosen to save herself—instead of saving the Western world? With Belgium complacent to the German, Paris gone, Calais gone—it would have meant another year on to the years we may have to fight, an extra five hundred million pounds of money, an extra hundred thousand lives. If ever country owed debt, this country owes it to Belgium, to keep the breath in the bodies of her people. Owes it, and must pay it.

In standing to her guns Belgium saved of course the whole world, for modern civilisation is built on nothing if not on good faith and honourable obligation; but it is France and Britain before all that she has saved. France, however, has a terrific task in the rescue of her own ruined millions in the north. Thanks, perhaps, to ruined Belgium, Britain has not, may never have, to rescue and restore ruined towns and countryside.

In return, what is Britain doing? Spending money and blood like water to drive the Germans out of Belgium? Yes! But let us be honest. We should have had to do that in any case for our own interest. We are not thereby discharging the debts of gratitude, justice, and humanity. Giving hospitality to 200,000 Belgians? It is something, but not enough. Not nearly enough! So far we have not faced at all the desperate situation of Belgium itself; we have not, indeed, been asked to. From Canada and Australia, with one-fifth of our population, help to the value of £150,000 a month has been coming in. From ourselves, practically nothing. But in future, all eyes are turning to us; it is we who are now asked to stay the march of death.

A penny of income tax in our country yields nearly three million pounds. If each one of us sets aside at once one penny from every pound of his income, this people is saved—this people more cruelly wronged than ever people were, this people to whom each one of us owes a debt, that we have not realised, that we cannot realise in its full proportions. If Belgium starves, the civilised world incurs a stain more black than we dare to contemplate: a little country gave itself for civilisation, and civilisation, having the means to save it, let it

perish! . . We are dealing here not with words, ideals, and what not, we are dealing with hunger—a very simple thing; if people are not fed, they die. No ultimate victories, vindications, and indemnities are of the least use to Belgians, starving now. If they are not kept alive—on the shoulders of this country, the richest country, and that which has gained most by Belgium's suffering, the reproach will lie heaviest. Verily it will!

There can be no exaggeration in the tale of Belgium's trouble—for no words can even begin to tell it as it should be told. There can be no exaggeration in the expression of gratitude for what we owe her. If those wronged and ruined people had done nothing for us, should we grudge them enough money to spare ourselves the sight of their starvation just across the sea under our very eyes? But seeing what they are, what they have done for us—how—how can we bear to let them lack the mere sufficiency of life?

No! Britain will not let Belgium starve. We have not known hitherto what was needed of us in this race with death. Now we *do* know. We are too proud by far not to pay our debts. For this is a debt of honour, preceding even the charity that begins at home.

The appeal of the National Committee has been issued. The Hon. Treasurer is Mr. A. Shirley Benn, M.P., Trafalgar Buildings, Trafalgar Square, London.

Every penny contributed goes to the Belgians in the form of food. The cry of a brave people comes across the sea. Pity, ungilded, feeds no starving bodies.—Yours truly,

(Signed) JOHN GALSWORTHY.

Flat A1, Adelphi Terrace House,
Robert Street, Adelphi,
London, W.C.
May 2nd, 1915.

Papers by Guy's Men.

Francis Heatherley, M.B., B.S., F.R.C.S.: Unsympathetic treatment of Territorial Medical Officers.—*Brit. Med. Jour.*, May 8, 1915.

G. Maxted, M.D., B.S., F.R.C.S.: A case of lacrymal concretions.—*Ibid.*, May 15, 1915.

C. A. L. Mayer, M.D., B.S.: Chronic intestinal stasis associated with Lane's Ileal Kink and Hypothyroidism. *Ibid.*, May 15, 1915.

N. Mutch, M.A., M.D., M.R.C.P.: The duodenum in diabetes (Illustrated).—*Practitioner*, May, 1915.

H. M. Page, F.R.C.S., Spinal anæsthesia in 43 suprapubic prostatectomies.—*Lancet*, May 15, 1915.

F. E. Shipway, M.B., B.C.: Discussion on the influence of preliminary narcotics on (*a*) Induction, (*b*) Maintenance, (*c*) After-results of anæsthesia.—Proc. of Roy. Soc. Med., Sect. of Anæsthetics, April, 1915.

W. Lindsay Locke, M.B., B.Ch.: The removal o foreign bodies from the tissues with the aid of an X-ray director.—*Ibid.*, Elect. Ther. Sect.

W. M. Mollison, M.A., M.C., F.R.C.S.: Removal of epithelioma of larynx.—*Ibid.*, Laryngological Sect.

Philip Turner, M.S., B.Sc., F R.C.S.: Hydrocephalus and spina bifida with deformity of the legs.—*Ibid.*, Sect. for Study of Dis. of Children.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Births.

BROMLEY.—On the 7th May, at the Warden's House, Guy's Hospital, the wife of Lancelot Bromley, M.C., F.R.C.S. (*née* Dora Ridgway Lee)—a daughter.

TURNER.—On May 8th, at Anerley Road, Upper Norwood, the wife of Capt. A. Scott Turner, R.A.M.C., of a daughter.

WATSON.—On May 10th, at Wootton Bassett, Wilts., the wife of J. N. Watson, M.R.C.S., of a son.

Marriages.

ATTWATER—HAWKINS.—On April 29th, at St. Margaret's Church, Westminster, Harry Lawrence Attwater, M.A., M.B., M.C., F.R.C.S., Temporary Lieutenant, R.A.M.C., to Nora Collingdon Hawkins, fourth daughter of Dr. and Mrs. Hawkins, of Hillfield, Broadwey, Dorset.

VERNÈDE—DICKSON.—On the 7th April, 1915, at Christ Church, Munoar, by the Rev. W. Bateman, Jean Scipior Archibald Ewart, eldest son of A. W. L. Vernède, Retired Superintendent and District Magistrate of Devilcolon Division of Travancore, to Kathleen Mary, only daughter of the late Rev. David Dickson, Vicar of Lowestoft, and Mrs. Dickson, of King's Lynn, Norfolk, England.

Deaths.

MASON.—On May 7th. at Wexham Cottage, Gorleston, Alfred Leighton Mason, L.D.S. Eng., aged 34 years.

NEELY.—On April 25th, killed in action at Ypres, Hugh Bertram Neely, L.D.S. Guy's, Second Lieutenant, 1st Suffolk Regiment, aged 26 years.

W. E. T.

GUY'S HOSPITAL GAZETTE.

VOL. XXIX., No. 703.] JUNE 5, 1915. [SIXPENCE.

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Passim.

IT is with great sorrow that we have to record the death of yet another Guy's man, Lieut. J. S. H, James, killed in action. Mr. James came up to Guy's from St. Paul's School in October, 1912. We offer our heartfelt sympathy to his parents and friends.

Lieut. C. H. Brewer has been seriously wounded. Mr. Brewer entered for the London M.B. course in October, 1913, after having studied at Cheltenham College, and passed the London Matriculation in January, 1913.

Snrgeon E. G. Schlesinger, R.N., serving with the *Howe* battalion in the Dardanelles, has also been wounded. E. G. Schlesinger had a brilliant career at Guy's, and in June last was appointed Surgical Registrar and Demonstrator of Anatomy, but, owing to the outbreak of war in August, he never served in that capacity,

Captain Winshall, 4th Royal Welsh Fusiliers, writes :—"I know you will be sorry to hear that poor Freddy Pern has been killed. We were in a scrap on the 9th, and lost our Colonel and four other officers, as well as the doctor. He was a real hero! Crawling about between our first and second line attending to the wounded, he was shot in the lungs by a machine gun. He was buried to-day (May 11th), and we shall miss him very much."

A Guy's man writes:—"I remember the meeting of Out-Patient Officers to sign up the Dressers for the three months when Pern was in the surgery. It is, at the present time, particularly pleasant to remember that there was one man about whom we were all agreed. From time to time there are men who pass through this Hospital, not particularly brilliant in any one line, but sound to the core all through; men to whom one instinctively turns in an emergency, or when an opinion of right or wrong has to be given. "Freddy" Pern was one of such men. It is reported that he lost his life while bringing in his Colonel; the incident exactly fits in with what we knew of Pern in his student days. The war is certainly taking our best!"

A CORRESPONDENT in British Guiana sends us the following verses, which refer to Guy's :—

ARMY DOCTOR.

(From the *Daily News.*)

Army Doctor! Army Doctor!
'Ere's some 'cruities for inspection—
Some in rags, an' some un cuffs,
Some in shirts, an' some without 'em.
Wot a blessed strange collection!
Served before? You needn't doubt 'em,
Bloomin' muffs!

Army Doctor! Army Doctor!
Take your sword, an' drop your lancit,
Teach your nurses 'ow to fight,
'Ow to march the dead march—solemn!
'Ow to route march—an' to dance it!
Teach 'em 'ow to march in column,
By the right.

Army Doctor! Army Doctor!
Gold an' velvit, 'broidered lacin's,
'Olding 'igh your blooming 'ead,
'Seen you peel that coat so winnin',
'Seen you stain them pretty facin's,
'Seen your 'ighly glossy linen,
Splattered red!

Army Doctor! Army Doctor!
' Sun is 'ot—an' we are learnin'
Lessons in the cholera school,
We're fear-sick, an' mad as 'atters,
Throat a-parchin', 'ead a-burnin',
Seems to me, you're takin' matters
Rather cool.

Army Doctor! Army Doctor!
Spurs an' swagger, cuff an' collar,
Up to ev'ry bloomin' trick.
' Seen you—as I've seen none other—
Go to where I dursn't foller!
' Seen you act the man an' brother
To the sick.

Army Doctor! Army Doctor!
Things by engineers forgotten,
You 'ave got to recollect,
Tho' you're such a gilded dandy,
When the meat is goin' rotten,
Chances are, you're somewhere 'andy
To inspect.

Army Doctor! Army Doctor!
Where the firin' never ceases,
Where the 'uddled soldier lies,
Where the Mauser bullets shave 'im,
Gawd! they're chippin' 'im to pieces!
Git 'im out of fire and save 'im . . . .
Well done, Guys!

EDGAR WALLACE.

Orange River, March, 1900.

We do not think medical students should be provided with badges to protect them from recruiting sergeants or other zealous people who may try to persuade them to enlist. If a man is convinced that he is doing his duty in a civil capacity, he must surely have the moral courage to explain his position to Government servants, and, on the other hand, treat politely any anxious females who may accost him.

If any man is uncertain whether he is doing his duty or not, it is just as well that he should feel uncomfortable. Until the Government takes up this question, every man must decide for himself whether he ought to join the Army or not.

The endless variety of badges now worn by civilians is one of the most unpleasant features of this great war. And in our opinion it is a contravention of the spirit of the Defence of the Realm Act to wear a badge or medal without authority from the Government to do so.

We are supposed to be engaged in a war against militarism, so let the soldiers have the badges and medals which are their due.

There is no doubt that men are wanted at the Front, so if a man has not the courage to be just a plain civilian, he should join the army at once.

The opinion of educated people in this country is that medical students should remain at their work. A Hospital badge is not counterfeit, and might enable the "real slackers" to go on their way unmolested.

Arrangements have been made to deal with any emergencies resulting from air raids. The authorities have a complete scheme for treating injured persons brought in from surrounding districts. In view of the possibility of a fire breaking out in the Hospital itself, an extra supply of sand buckets have been placed in the wards and corridors, and the water hoses are all in order.

We are told that when a raid is expected the best thing to do is to close the lower windows; but we imagine that an exploding bomb will break most of the windows, and expose the occupants of the wards to the effects of asphyxiating gases. If there is any reason to suppose that an air raid is to be attempted, Mr. Saltmarsh will be called, and remain on duty during the night to summon the men and Residents should occasion arise to do so.

As the risk of raids may last for six months or more, there is no need to keep a large number of men up all night who have work to do during the day. The novelty of such a vigil would soon wear off.

Sister Charity will shortly be leaving the Hospital to take up the post of Matron to the Tong Shan Hospital.

MR. FINNEMORE, the Hospital Pharmacist, has temporarily vacated his post to join the Officers' Training Corps for the duration of the war.

THE Coolidge X-ray tube has proved so highly satisfactory that another one has been ordered.

AN O.P.O. sends us the following note concerning her child, from an anxious mother :—

"Excuese me Doctor I cannot speak Englesh so I wirte it on this paper. I always go to Guyes Hoppital From several months she will not eat anything I make her eat and she sicks it out, and she is waisting, she is open every day, and she does not drink anything."

Pass List.

Society of Apothecaries.

At Examinations held recently the following candidate passed in the subjects indicated.

Medicine (Sect. I. and II.).

A. H. Taymour.

Forensic Medicine.

A. H. Taymour.

Royal College of Surgeons of England.

At the Primary Fellowship Examination in Anatomy and Physiology held on May 5th, 6th, 10th, 11th, the undermentioned candidate was successful.

Jack Joffé.

University of London.

THIRD (M.B., B.S.) EXAMINATION FOR MEDICAL DEGREES, MAY, 1915.

J. F. H. Stallman.

GROUP II.

P. D. Scott.

BOOKS, ETC., RECEIVED.—The St. Bartholomew's Hospital Journal, The British Journal of Dermatology, The Hospital, The Nursing Times, The Middlesex Hospital Journal, The St. Thomas's Hospital Gazette, The Polyclinic, The Dental Elevator, The Prescriber, The South African Medical Record, The Medical Journal of South Africa, The St. Mary's Hospital Gazette, The M.S. Journal.

Change of Address.

Lieut. W. A. Easton, R.A.M.C., Officers' Mess, R.A.M.C. Camp, Eastbourne.

Lieut. Harold Webb, R.A.M.C., No. 22, General Hospital, British Expeditionary Force, c/o G.P.O.

Lieut. D. C. Scott, R.A.M.C., 35th Field Ambulance, 11th Division, Frensham Camp, Farnham.

Lieut. G. E. Lockyer, R.A.M.C., 7th Batt. Wilts Regiment, Sutton Vendy, Wilts.

Papers by Guy's Men.

J. Lee Atkinson, M.R.C.S., L.R.C.P.: The appendix and the genito-urinary apparatus.—*Med. Journ. of Australia*, April 17th, 1915.

A. E. Boycott, M.D., B.Ch., and another: An attempt to discuss the composition of tissue fluids in normal and nephritic animals.—*Journ. of Path. and Bact.*, April, 1915.

C. H. Fagge, M.S., F.R.C.S., and E. C. Hughes, M.C., F.R.C.S.: An analysis of a consecutive series of cases of various forms of arthritis, treated by ileocolostomy or by colectomy.—*Brit. Journ. of Surgery*, April, 1915.

Sir W. Arbuthnot Lane, Bart., M.S., F.R.C.S.: The operative technique of ileocolostomy and colectomy.—*Ibid.*

N. Mutch, M.D., B.C., M.R.C.P.: Bacterial activity in the alimentary tract.—*Ibid.*

J. Lewin Payne, M.R.C.S., L.R.C.P., L.D.S.: Art and prosthetic dentistry.—*Brit. Dent. Journ.*, May 15th, 1915.

Lawrie McGavin, F.R.C.S. Eng.: Tuberculosis of the right knee-joint.—*Clinical Journ.*, May 19th, 1915.

W. Warner Cook and another: Fracture of the Pelvis with extra peritoneal rupture of the bladder.—*Lancet*, May 29th, 1915.

A. E. Larking: The Medical Defence Union and the National Insurance Commissioners.—*Ibid.*

Lieut.-Col. C. E. Pollock, R.A.M.C.: Notes on the incidence of malaria among European troops in the Sierra Leone Command, with special reference to the effect of mobilization.—*Journ. Roy. Army Med. Corps*, February, 1915.

——: Salvarsan in malaria.—*Ibid.*

Capt, D. P. Watson, R.A.M.C., and others: Description of a stain of trypanosoma brucei from Zululand. Part III., Development in glossina morsitans.—*Ibid.*

Major A. J. Hull, R.A.M.C.! Memorandum on the treatment of wounds of the knee-joint —*Ibid.*

Captain E. A. Peters, R.A.M.C. (T.F.), M.D., F.R.C.S., and another: Cerebro-spinal fever and the sphenoidal sinus.—*Lancet*, May 22nd, 1915.

Captain Hugh Stott, I.M.S.: Studies in Malaria.—*Indian M. Gaz.*, May, 1915.

Vitalism and Mechanism.

A Paper read before the Guy's Physiological Society by L. S. DEBENHAM.

MR. CHAIRMAN AND GENTLEMEN,—In the Middle Ages it would have been a crime of the most blasphemous character to have taught that Life was other than God created and God maintained. Even in the 18th Century Darwin and Huxley were rigorously denounced by the Church because their doctrines were held to cast aspersions on the truth of the Bible; whereas, in these more open-minded times, it is no unusual occurrence to hear casual references to evolution as an accepted fact from the pulpit itself. The Freedom of Thought, then, has permitted an attack on the problem of life, and a controversy has resulted as to whether the forces and matter which belong to the inorganic world may not also entirely account for living phenomena, or whether a mysterious agency, peculiar to life, is not a necessary adjunct.

Life, in itself, is extremely hard to define, and most attempts thereat savour rather of Sidney Smith's famous definition of an archdeacon as being "one who performs archdiaconal functions." The difficulty lies in the fact that the animate and inanimate tend to become more and more inseparable, the accepted attributes of life being shown more and more to be physical and chemical phenomena. Leduc defines a living being as "a transformer of energy and matter, containing certain albuminous substances of essentially liquid constituency: the conservation of the individual being due to a harmony of the processes; which harmony is life: discord is disease: and total cessation is death." The problem at issue is, then, to explain the harmony on purely chemical and physical lines, or, on the other hand, to controvert these attempts and show the necessity for a guiding influence.

The distinction between the organic and the inorganic was formerly most marked, but is now gradually disappearing. Chemists have surmounted a quondam insuperable barrier, for the chemistry of life is shown to be relatively simple: the elements of living tissues are those met with in the inorganic world, and, moreover, they have all come from and eventually pass back to this same sphere, so that all inorganic material has the essence of life, potential in the mineral, actual in the organism. Energy, too, has a circulation from the inorganic world, through the organism, back whence it came, the law of conservation being strictly observed in living tissues. Finally, the work of Wöhler, who first produced urea from inorganic material, and the labours of other chemists culminating in the synthesis of protein material by Fischer, have shown that time alone intervenes before all the substances which go to make living tissues are synthesisable.

The attributes of life are imitable in undoubtedly lifeless matter: movement of amœboid character is seen in drops of oil, and is due to changes of surface tension. Now, all macroscopical movement is ultimately dependent on changes in separate cells and, therefore, may quite well be due to such changes of surface tension in the cell substance. Osmotic growths may be shown to take up "nutriment" according to their kind from their mother liquor, to "metabolise" it into an acceptable form, and to "excrete" the residual products. Growth also is seen in these osmotic phenomena and resembles this attribute of a living being inasmuch as it occurs by the process of intussusception and resembles the lower types of life, not only in external appearance, but also in the similarity of internal structure.

Lastly, reproduction, "the essence of life," is observed in crystals, whilst a process of rejuvenation may be quite simply performed on any osmotic growth. So, then, we may no longer look on life as essential to the manifestation of these phenomena, for are they not exhibited in ordinary mineral material?

If, now, chemical and physical forces will account for life, it is necessary to go back to the beginning to discover, if possible, the transition from the unorganised to the organised; for, unless we believe in special creation, there must have been a bridge across the abyss which separates the two spheres.

The doctrine of spontaneity, as supported by the appearance of organisms in sterilised flasks, is quite untenable; for why should such relatively highly evolved organisms appear in such unsuitable media? Rather let us turn to the other hypothesis, that a transition occurred between the organic and the inorganic. Need we limit the transition to one period in which circumstances were especially favourable? It may be that it occurs to-day passing unnoticed beneath our eyes, in that it must result in some form of life far simpler than any of which we are cognisant. Moreover, the lack of geological evidence is not fatal, because disseminated particles or even colloidal masses of slime, or whatever form the first life takes, could not leave any impression on a geological formation: millions of years must have elapsed before the first spicule-skeleton was evolved.

When the first step in the transition is made, the law of natural selection will help us all the way up to the primate animal. We can imagine the evolution, after myriads of years, of a phosphorised portion, probably disseminated, but whose function was chiefly catalytic. Now catalysis is quite a chemical process, as Bredig has shown, and, moreover, there is a marked similarity between inorganic and organic catalysers, in that they are affected alike by temperature and reaction, and may both be poisoned by such substances

as HCN and H_2S. The evolution of the cell with collected nuclear matter would follow. Now previously, when the slime became too cumbrous, it would divide just as a crystal does, but now the introduction of a nucleus causes a complication of the simple division. However, Leduc demonstrates that all the phenomena of nucleus division—kanyokinesis—may easily be exhibited in mineral fluids, where pigment particles represent chromatin, and changes of concentration provide the necessary forces. The cohesion of separating parts of a cell division would form the first metazoon, and here, again, Leduc shows that the forms taken by masses of diffusing liquids imitate very closely the morula and, later, the gastrula which are observed in the lower metazoa and as first stages in the development of the higher members.

The way is now open to the play of natural selection, whereby the more perfected organisms may be evolved.

However, the secret of the advance in evolution is the degree of co-ordination whereby the different parts of an organism are regulated to the needs of the other parts and of the organism, as a whole at any moment. In this co-ordination are two factors: the influence of the central nervous system, and the internal secretions.

The wonderful complexity of the central nervous system with its attributes as exhibited in man may all be traced back to the metazoon, some of whose ectodermal cells became more sensitive to stimuli than usual. The connection of these cells with neighbouring parts, their sinking into the tissues for better protection and nourishment, give the steps towards the evolution of a nervous system which has gradually evolved to such a marvellous extent. However, the degree of development, as far as we can judge, depends on the state of consciousness exhibitable, and of this consciousness we are unable to give a physical explanation; but, does it matter? Consciousness is but an accompaniment, and has no influence on the mechanical processes, although it is very dependent on the chemical and physical environment. Let the oxygen supply to the brain be cut off for a very short time and consciousness vanishes!

On the other hand, the physiology of the internal secretions is only in its infancy, but sufficient is known to show that the bodies, whose chemical composition is relatively simple and in some cases so accurately known that they have been synthesised, have an important role to fulfil. Consider the thyroid, pituitary, sexual organs, pancreas, and others. What grave disorders arise from the excess or deficiency of their internal secretions! It is to be admitted that certain secretions appear under the influence of the nervous system, but it is equally true that the maintenance of harmony in the latter depends on other internal secretions; there is, thus, a degree of interdependence.

There seems, then, no flaw in the argument which assumes that life is merely a specialised exhibition of chemical and physical phenomena. Investigation along such mechanical lines, using essentially chemical and physical methods, elicits chemical and physical facts, so that physiology is merely applied chemistry and physics obtaining but partial answers to its questions, but the rest is admittedly speculation. Since the employment of such proceedures, progress of immense and undeniable degree has ensued. The goal has been found to be farther away than was anticipated, but this does not constitute a valid argument against the mechanistic doctrine. The complexity of the means of co-ordination is only natural, when the process of evolution is considered, and such evolution is essentially an automatic process wherein a useful development causes the survival of an individual and the transmission to its successors. This transmission would follow quite well on the lines of Weismann's theory, whereby the generative nuclei are considered to contain the representative mechanisms for the furnishing of the new generation.

From the beginning to the end of life, with all the processes thereby entailed, no other guiding influence than the laws of the inorganic world need be considered.

However, there is in every one of us a feeling of revulsion against the thought that we, as individuals, are mere mechanisms exhibiting the same phenomena as an osmotic growth. It is our vanity to think that there is some other agency which guides all the intricate processes and which is, in fact, the harmony that constitutes life. Now, the endeavours of physiologists in successive generations to uphold this view on scientific grounds have not met with lasting success, for the hypothesis is incapable of experimental proof; consequently the theory serves generally as a refuge to those who discover the fallacies of the mechanistic explanations, as Kant says, "a convenient resting place where reason can repose on the pillow of obscure qualities." The only arguments that can be brought forward in favour of vitalism are those which show the failure of the other theory to explain the phenomena of life.

The use of chemical and physical methods in physiology is quite legitimate in that we are incapable of recognising anything else. Our sense organs, on which we depend for our perception of occurrences in the external world, are essentially adapted to receive the various forms of motion exhibited in all chemical and physical phenomena. The answers obtained by such methods can only be expressed in mechanical terms; but to say that physiology is applied chemistry and physics because such methods are employed is as absurd as to maintain that the latter are branches of physiology because scientists use their brains. The great advance is undeniable, but to what

has it led? The goal always retires farther into the mist of obscurity, and even if the methods were pushed to their ultimate end, a knowledge of the sequence of events and laws observed in living phenomena would be obtained; but these would be as far from explaining life as the law of gravity is from stating *why* two bodies move together with uniform acceleration!

The advance has shown the grosser activities of life on mechanical laws: respiration depends on the laws of aerodynamics; the circulation ultimately comes down to hydrodynamics; the digestive processes may be shown in vitro when the enzymes are extracted from the alimentary canal and its glands; but these explanations are far from telling us what processes occur in the respiratory muscles, or in the individual heart muscle cells which cause such a marvellous regulation and adaptability. Why do the gland cells secrete enzymes, or why do other glands work against osmotic pressure to produce secretions for the maintenance of the organism? The sense organs are physical apparatuses par excellence, but they give no hint of the process in the cerebral cells whereby the impulses are interpreted. "The processes explained on mechanical lines," as Bunge says, "are no more phenomena of life than the rustling of the leaves of a tree shaken by the storm."

The controversy, then, must be narrowed down to an explanation of cell activity, and it is precisely at this point that the mechanistic view breaks down. It is advanced by some authors that there is a vastly complex intracellular mechanism which is capable, on purely chemical and physical lines, of performing all the functions exhibited by the cell, and that this mechanism will be elucidated in time. Such a pious hope is far from constituting positive evidence. Moreover, consider the delicacy of co-ordination; for instance, the respiratory centre, which is extremely sensitive to changes in hydrion concentration, and the kidney, which reacts so as to keep the blood as constant as possible with regard to the same factor. Each cell would have to contain a vast number of mechanisms and adjust itself to millions of others in other cells. Again, these mechanisms must be transmitted to the next generation and must, therefore, be contained entirely in the nuclei of the ovum and spermatozoon. Weismann calls the substance "germplasm," but is this any more intelligible? Can we believe that a substance, which is mixed like so much treacle and immediately pulled apart again, can support the vast, stupendously complex structure which has to supply the mechanisms for the whole adult body and provide for their orderly arrangement?

Let us take another aspect. Du Bois Reymond points out that the ultimate end of chemical and physical investigation is to reduce all matter to motion of atoms; if the method succeeded in probing the problem of life to the bottom, the whole universe would be reduced to a formula, wherefrom, by taking suitable values, the position and motion of any atom at any moment could be ascertained. But this is not a lasting satisfaction, for the obvious query is, "What is an atom?" The smallest indivisible part of a body —but being bodies themselves with the characteristics of bodies—the one phenomenon is explained by the introduction of another.

Further, suppose that every atom could be followed, we should be able to watch our own mental processes and observe the particular dance of atoms which accompanied the acme of sense-enjoyment, or the storm which corresponds to the frantic pain of trigeminal neuralgia. We should convince ourselves that consciousness accompanied, and was dependent on, atomic motion, but we should be unable to say how consciousness arose.

The mechanistic doctrine fails to explain cell activity and the phenomenon of life, but does it follow that vitalism is right? At the most its claims lie in the inability of the other theory to materialise. Physiology has realised that progress can only be made by elucidating the mysteries of the cell, and the relegation of the phenomena to a mysterious agency would be as much a hindrance to research as the adoption of the doctrine of special creation to biology.

Moreover, it is asserted that such a regulating agency would necessitate the production or destruction of a certain amount of energy, and even if both proceedings occurred in the same organism, there should be some indication of the changes. The defence that the changes are too small to be recognised may not be retained, for such an important established principle as the law of conservation of energy may not be set aside except on very definite positive proof.

What, then, are we to hold? Johannes Müller propounded the law of specific energy of nerves, from which it is apparent that we cannot absolutely rely on the impressions we receive from our sense organs in that the same stimulus will give rise to different effects when applied to different sense organs, whilst different stimuli produce the same effect on the same sense organ. It is, therefore, necessary to start from the internal known world of our own consciousness and work out to the external unknown world, rather than the reverse proceeding adopted by the mechanists.

However, psychology is not an exact science and permits of no quantitative measurements of the objects of our internal sense, so that the internal known world is, at most, very vague.

We have, then, to proceed along mechanistic lines in chemistry and physics as far as possible, and where these sciences bring us to an impasse, the prominence of the failure will lead up to the vitalism of the future.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR,—I am enclosing an "Ode to the Pelvis," composed by some of the P.T.S. nurses at Queen Charlotte's Hospital, whose brains this month seem to run in humorous grooves, rather than in ability to grasp the anatomy of the pelvis.—Yours truly,

I. ALLEN.

268, Marylebone Road, N.W.
May 27th, 1915.

The pupils of the P.T.S. with one voice :—

"Pelvis, O Pelvis,
We try so hard to tell
The details of your structure,
The charms we know so well.
We think of you at night time,
We ponder you all day,
Can repeat all your diameters,
With your bones we are *au fait*.
And yet, when we are questioned
About you by the sister,
Your cavity becomes to us
A never-ending vista!
To our dazed minds the Foramen
Take on the shape of spines,
And we find *at least* a dozen
Of pectineal lines—
The Ischial tuberosities.
On which we daily sit.
Change places with the Pubic bones
But somehow they don't fit.
The Symphysis and Sacrum
We simply *can't* explain,
And sister asks the oblique
Of the Outlet, but in vain.
The joint called Sacro-iliac
We will insist on placing
On the Pectineal Eminence,
And we are always chasing
The ligament called Poupart's
From a perch upon the Plane,
Yet when sister asks us next day,
Well, we find it's there again.
And daily, almost hourly,
In our minds we try to fix
The relative positions of
The Sacrum and Coccyx;
But of all the tricks you play us
The worst is when we pine
To describe the situation
Of *one* elusive spine!
In our diseased imaginings
It is multiplied by ten,
We stick it *everywhere* we can;
O Pelvis, tell us when
Shall we, when sister asks us
For th' External Conjugate,
Describe that spine correctly
And not have to debate
Within our addled noddles
Exactly *where* we are
When we talk about that wretched spine
Of the last Lumbar Vertebra!"

SIR,—At a recent meeting of the Officers under my Command, I gave the following details of the work accomplished since the outbreak of war by the 2nd London General Hospital and its Sections.

All the Officers doing duty at this Hospital are members of the Staff of either the London, St. Thomas's, or Guy's Hospital, and it was suggested that your readers would be interested in these figures.

I have much pleasure, therefore, in forwarding the following statement.

Total numbers admitted to Hospital, between August 5th, 1914, and May 4th, 1915.

Expeditionary Force:—	
Officers	312
Rank and File	3,719
	4,031
United Kingdom:—	
Officers	29
Rank and File	3,013
	3,042
Grand Total — 7,073	
Deaths:—	
Expeditionary Force	18
United Kingdom	20
Total ...	38
Invalided out of the Service:—	
Expeditionary Force	178
United Kingdom	218
	396
Numbers under treatment in Hospital on May 4th:—	
Expeditionary Force	539
United Kingdom	328
	867
Total returned to Duty:—	
Expeditionary Force	3,396
United Kingdom	2,476
	5,872

There were 52 Officers in Hospital on May 4th, 1915.

2nd London General Hospital, I am,
St. Mark's College, Your obedient Servant,
Chelsea, S.W. E. M. CALLENDER,
19th May, 1915. Lt.-Col.
Comdg. 2nd London General Hospital.

DEAR SIR,—I should like to draw your attention to the annoyances to which we medical students are subjected regarding the recruiting question.

The British public, in their patriotic enthusiasm, accost all and every male civilian, and we, having nothing by which we can be distinguished from the ordinary layman, are designated "slackers."

I suggest that we wear some distinctive badge, and so put a stop to the unpleasant remarks which we hear on all sides. For the puhlic *must* recognise the necessity of doctors.—Yours truly, W. R.

Guy's Hospital,
May 31st, 1915.

DEAR SIR,—Could not some method be devised, by means of a badge for instance, to distinguish the Medical Student from a "slacker," thereby saving the former from the unpleasant experience of being accosted daily by recruiting-sergeants who, at present, have no means of telling one from the other? Our workers for the Government have a badge, "On War Service," and it seems to me that the man who is staying at hospital and finishing his curriculum should be likewise protected.—I am, yours truly,

"NOT A SLACKER."

Zenda, Ashtead, Surrey.
June 3rd, 1915.

DEAR SIR,—At the request of many students of this Hospital, I wish to suggest through your columns that badges of some kind be given to the students to indicate that they are doing their duty by remaining at the Hospital during the war.

Hospital students are continually being stopped and asked why they have not enlisted, etc., and a badge bearing the Hospital name would avoid, to a great extent, the repetition of these questions. I have heard that students of some other London hospitals are supplied with badges.—I am, Sir, yours faithfully,

Guy's Hospital, DENTAL STUDENT.
June 1st, 1915.

DEAR SIR,—It would be interesting to know whether any other nurse or doctor has met a case of measles similar to that I am now nursing. My patient is a lady, the mother of two children, one 2 years, the other 7 months; both had a slight cold. The mother did not feel well three days before the rash, but there was no cold. On the second day the rash was raised and blotchy all over the face and neck, T. 104°, eyes rather blood-shot. Slowly the rash extended down the arm and trunk, and last of all on the legs. It did not disappear on pressure, and became hæmorrhagic on the fifth day on the breasts, forearm, and inside the thighs. The fading away began on the eight day.

This is now the eleventh day and the hæmorrhagic rash now is still well marked, and the skin is peeling very much like scarlet fever. The face has cleared except for the peeling, and under the skin of the brow it plainly shows and comes up when the patient laughs or gets warm. I nursed 42 cases from a school previous to this, and have nursed measles in hospital, but have never seen a measles rash like this.

Childe-Okeford Manor,
Blandford,
20th May, 1915.

SIR,—Will you allow me to bring before the notice of Guy's men the opportunity which now occurs for medical men to undertake executive work in the R.A.M.C. (T.)

Whilst fully realising that there is a paucity of medical men left to undertake house appointments, etc., I still hope there may be one or two men who would be willing to take a commission in the 3/6th London Field Ambulance.

The opportunity of seeing active service at an early date is excellent, as Drafts are constantly required, and as soon as an Officer knows his work he would probably be able to go out. All Officers in a Field Ambulance are mounted, but there is no difficulty about riding lessons here in the case of a candidate who cannot already ride.

The work is both varied and interesting. First Aid, Squad and Stretcher Drill, Field Sanitation and Cooking, management of Dressing Stations, urgent operations such as amputations, ligature of arteries, etc.

On taking a commission, there is a grant which covers the entire cost of uniform and equipment. Pay with additional allowance for lodging, fuel and light, begins at once.

I should be very glad to see or write to any old Guy's man who would care to join me here.—Yours very truly,

P. SEYMOUR PRICE, Lieut. R.A.M.C. (T.)
Duke of York's Headquarters,
Chelsea, S.W.

Appointments.

Civil.

E. C. Bevers, M.A., M.B., B.Ch. Oxon., F.R.C.S. Eng. and Edin., Surgeon to the Radcliffe Infirmary and County Hospital, Oxford.

Arthur E. Boycott, M.D. Oxon., F.R.S., has been appointed Director of the Graham Research Laboratory.

B. T. Verver, M.R.C.S., L.R.C.P., District Medical Officer of the Basford Union.

Naval.

Temporary Surgeon B. Sampson, to Haslar Hospital.

Surgeon H. E. Perkins, R.N., to the *Pembroke*.

Surgeon G. B. Cockrem, R.N., to the *Vivid*.

Royal Army Medical Corps.

To be temporary Lieutenants:—J. S. Bookless, G. E. Lockyer, E. E. Frazer, C. E. Price, G. S. Miller, W. A. Easton, G. F. Hardy, W. G. Brett.

G. A Wright, late Lieut.-Col. R.A.M.C. (T.F.), to be temporary Lieut.-Col. whilst serving at the Military Hospital, Whalley.

Temporary Lieutenant Owen Richards, to be temporary Captain.

2nd London Sanitary Company:—To be Lieutenant, A. E. Rayner.

John Atkins to be temporary Colonel (dated Oct. 20th).

Lieut.-Col. E. B. Dowsett, from 5th London Field Ambulance, to be Assistant Director of Medical Services, 2nd London Division, with the temporary rank of Colonel.

A. D. Crofts, to be M.O. to the 4th Reserve Battalion, Coldstream Guards, Windsor.

The undermentioned Captain relinquishes his temporary commission on ceasing to serve with the Duchess of Westminster's War Hospital:—T. M. Body.

D. F. Small, to be 2nd Lieut., Cheshire Regiment.

Syphilis of the Cardio-Vascular System.

CLINICAL LECTURE BY HERBERT FRENCH, M.A., M.D., F.R.C.P.

SYPHILIS OF THE ARTERIES (*continued*).

GENTLEMEN,—In our last lecture we were discussing endarteritis obliterans and its effects, and now we will pass on to the second of the main ways in which syphilis affects arteries—namely, atheroma.

The essential changes which constitute atheroma were discussed briefly in our last lecture, and I also drew attention then to the way in which syphilis produces these atheromatous changes, particularly in the region of the aortic valves themselves and in the first few inches of the aorta above the valves, often leaving the distal part of the aorta comparatively healthy. There are, of course, cases in which syphilis affects the aorta from end to end, but these are relatively uncommon. The atheromatous change produced by syphilis is of a softer type, less prone to calcification and of a much more boggy feel than when corresponding changes are due to age or alcohol without syphilis. There is also more inflammatory trouble, more round-celled infiltration, and more softening of the middle and outer coats of the aorta in relationship to the atheromatous patches when syphilis is the cause, and it is on this account that the syphilitic variety is much more liable than other kinds of atheroma to lead to aortic aneurysm. Indeed, when a person is suffering from aneurysm of the aorta it is almost certain that he has had syphilis, just as when tabes dorsalis develops it is practically certain that there has been syphilis in the past, notwithstanding any history the patient may give to the contrary. There are probably a few exceptions to both these rules, but the exceptions are, I think, very rare.

Any of you who may be going in for the Durham examination ought to make yourselves particularly familiar with the subject of aneurysm, for there are far more cases of aortic aneurysm in the north of England than in the south, and you are almost certain to find several aneurysm cases in Newcastle Infirmary. The reason for this is, I suppose, that in addition to syphilis—which may be quite as common in the south as in the north—in the north there is a larger proportion of very hard physical workers engaged in iron foundries, furnaces, mines, and so forth, and the two factors which, added to syphilis, are of greatest importance in producing aneurysm are hard physical work and alcoholism.

This leads us to a discussion of aneurysm in general, and you will find it helpful, I think, to consider the question of aneurysm not as one big whole, but, from the clinical point of view, at any rate, by sub-dividing it into sections according to the part of the aorta from which the aneurysm is bulging. An aneurysm projecting in a particular site may produce particular symptoms and signs which it is not possible for an aneurysm in some other site to produce at all; and in a broad way one can classify the types of symptoms to which aneurysm can give rise into five groups, according to the anatomical situation of the aneurysm itself. These groups are as follows:—

1. When the aneurysm affects that part of the aorta which lies between the aortic valves and the origin of the innominate artery.

2. When the aneurysm arises from the next inch or two of the aorta—namely, the first part of the transverse arch, including the origin of the innominate artery.

3. When the aneurysm involves the distal half of the arch of the aorta in the part corresponding roughly with the origin of the left sub-clavian artery.

4. When the aneurysm arises from the descending thoracic aorta beyond the level of the left sub-clavian artery.

5. When the aneurysm arises from the abdominal aorta.

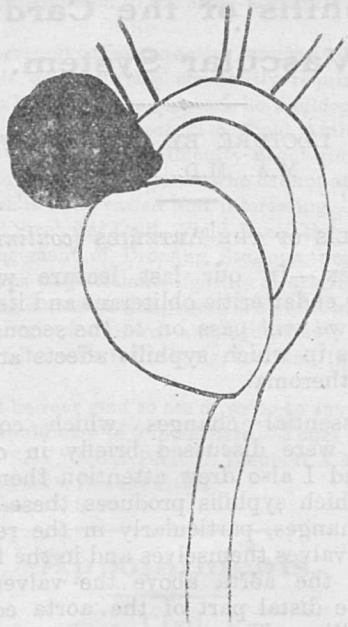
There is little need to worry, from a clinical point of view, as to whether the aneurysm is fusiform or saccular; and a dissecting aneurysm, such as I show you here, is so rare and has such acute and generally fatal symptoms that I will not discuss it further with you to-day.

We may also get rid of aneurysms of the abdominal aorta relatively quickly, for they are very rare compared to thoracic aneurysms. They nearly always occur at the same site in every patient—namely, somewhere about the origin of the coeliac axis artery. The main evidence of aneurysm here is abdominal pain, generally referred to some point between

the xiphisternum and the umbilicus, or alternatively, pain in the back in the dorso-lumbar region, and the diagnosis of the aneurysm is either exceedingly easy or it is so difficult as to be almost impossible. It is important to realise how rare abdominal aneurysm is in a woman, although extreme pulsation of the abdominal aorta is very common in the female sex. Mere antero-posterior pulsation of the aorta does not indicate an aneurysm, but if there is definite expansile pulsation and a tumour, anybody, even without experience, can recognise what is wrong. On the other hand an aneurysm instead of bulging forward and producing a pulsatile tumour very often bulges backwards or laterally filling in the concave space beside the vertebræ and eroding the bodies of the vertebræ between the inter-vertebral discs. In such cases expansile pulsation cannot be felt, and the diagnosis may be so difficult that even the wisest will miss it. The patient may be thought to be malingering or to have a gastric or duodenal ulcer, or chronic pancreatitis, and I have even seen the abdomen opened and the surgeon's hand inside the abdomen without the nature of the case being recognised, until later on there was a spontaneous rupture of the aneurysm and the diagnosis suggested by the sudden blanching was verified in the post-mortem room.

This leaves us with the discussion of the four main types of thoracic aneurysm, and I think you will see that it is only a question of thinking just what is the position the aneurysm occupies for you to be able to put down on paper the various physical signs and symptoms to which each type can give rise. It is clearly impossible. for example, for an aneurysm of the aorta close above the valves to cause paralysis of a vocal cord; it is equally impossible for an aneurysm of the descending thoracic aorta to stenose the superior vena cava or to lead to pain radiating down the right arm; and so on in other cases.

Let us consider each type in turn with the help of these diagrams that I will draw you on the blackboard. You will, of course, appreciate the fact that an aneurysm is often irregular in shape and not simply rounded as I have drawn them, and therefore that the symptoms and signs vary in different cases, even though the site of origin of the aneurysm may be the same. Broadly speaking, however, the things you would expect to find as the result of aneurysm in each of the four main positions I have described are as follows:—



Type 1.

Aneurysm of the first part of the Aorta, close above the Aortic Valves.

Type 1. (Fig. 1).—*Aneurysm affecting that part of the aorta which lies between the aortic valves and the origin of the innominate artery.*

An aneurysm in this position may be quite small and lie almost entirely inside the pericardium, producing neither symptoms nor physical signs until sudden rupture occurs, as was the case with the specimen I showed you at the beginning of our previous lecture. Such a relatively minute aneurysm is practically undiagnosable. If of larger size it will project to the right of the upper part of the sternum and cause an impairment of percussion note, especially in the second right intercostal space to the right of the sternum, and you would be on the watch for expansile pulsation in this same space, such pulsation being sometimes much more obvious to the ear placed upon the chest wall than it is to the hand laid flat upon the chest. In the detection of small degrees of pulsation the ear used in this way is a most valuable aid in diagnosis. The question of bruits in relationship to this or any other aneurysm I will discuss later. If the aneurysm we are now discussing produces any pain at all it will be in the front of the chest near the base

of the heart, and to the right side of the sternum rather than to the left; in addition to which the patient will very likely suffer from attacks of acute angina pectoris coming on in paroxysms, with a gripping sensation in the precordial region and pain radiating from near the apex of the heart inwards towards the sternum, upwards to the left shoulder and extending a variable distance down the left arm, generally on the ulnar side, usually stopping at or near the elbow, but occasionally extending as low down as the little and ring fingers of the left hand.

There will be a tendency for the superior vena cava to be obstructed by the aneurysm, so that there may be some cyanosis out of proportion to any tendency there is to heart failure, and in bad cases there may be swelling of the face, neck, and arms, with distension of the superficial veins upon the chest wall. Upon the whole, however, although an aneurysm in this position must nearly always interfere with the superior vena to some extent, it is remarkable how much less the latter becomes obstructed by aneurysm than it does by new growth; so that it is generally a good argument to say that if the alternative diagnoses lie between intra-thoracic aneurysm and intra-thoracic new growth, the greater the distension of the veins upon the chest wall the more likely is the condition to be one of growth than of aneurysm. Perhaps the reason for this is that the aneurysm, as it enlarges, pushes the superior vena cava outwards away from itself, but does not actually alter its wall, or, at any rate, its endothelial lining, so that there is not the same tendency to clotting within the superior vena cava that there is when there is new growth which, besides actually pushing the superior vena cava away from its normal position, infiltrates its wall and very often alters the endothelial lining by causing sprouts of new growth to project into the interior of the vein. It is particularly when the endothelium has been interfered with in this way by growth that thrombosis is added to the other factor in the occlusion, whereas in the case of an aneurysm such thrombosis is relatively less likely.

The right upper bronchus is apt to be interfered with in a similar way, especially if the aneurysm bulges backwards; so that one would be on the watch for impairment of note over the right upper lobe with harshness of breathing there, and possibly a few crepitations at the right apex which might easily simulate phthisis, especially as the obstruction to the bronchus by the aneurysm often causes a little hæmoptysis occasionally as well.

An aneurysm in the position we are discussing now will not, if you think of it, interfere with the cervical sympathetic on either side, so that the pupils would be equal.

It will not interfere with either recurrent laryngeal nerve, so that there is no vocal cord paralysis.

It will not, as a rule, be sufficiently adherent to the main respiratory passages to cause tracheal tugging.

It will not be far enough back to stenose the œsophagus.

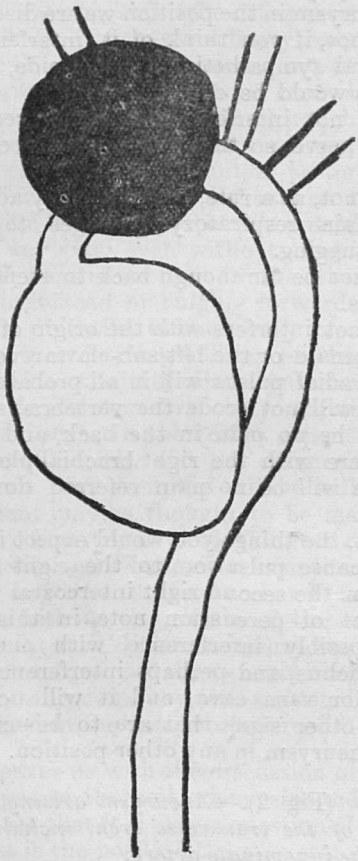
It will not interfere with the origin of either the innominate or the left sub-clavian veins, so that the radial pulses will in all probability be equal; it will not erode the vertebræ, so that there will be no pain in the back, and it will not interfere with the right brachial plexus, so that there will be no pain referred down the right arm.

In short, the things you would expect it to do are: To cause pulsation to the right of the sternum in the second right intercostal space; impairment of percussion note in this same space; possibly interference with the right upper bronchus, and perhaps interference with the superior vena cava, and it will not produce the other signs that are to be expected from an aneurysm in any other position.

Type 2. (Fig. 2).—*Aneurysm arising in the first part of the transverse arch, including the origin of the innominate artery.*

This aneurysm, like the one we have just discussed, will tend to cause pulsation and, perhaps, a tumour in the second, and probably also the first right intercostal space close to the sternum, with impairment of note to the right of the sternum in these spaces. It will also tend to stenose the superior vena cava; it may interfere with the right upper bronchus and cause abnormal physical signs in the upper lobe of the right lung, but in addition to the above it will tend to interfere with the origin of the innominate artery, and so cause the right radial pulse to be delayed behind the left, or even to be actually smaller than the left. It will very likely be adherent to the trachea so as to produce tracheal tugging, which is tested for by holding the hyoid bone between two fingers, whilst the patient's chin is slightly raised; and it may interfere with the right cervical sympathetic and so cause the pupils to be unequal; irritation of the right sympathetic causing the pupil to be dilated, paralysis of it causing it to

become constricted, and there may be slight ptosis on the right side also.



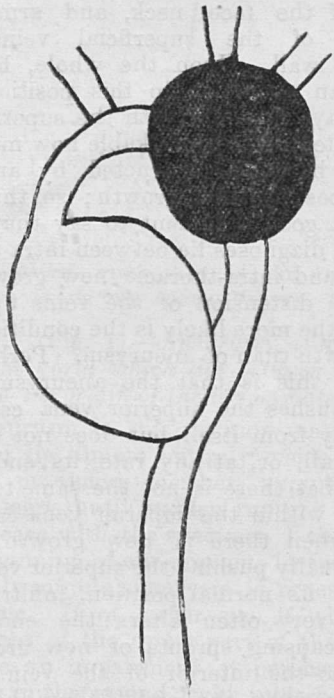
Type 2.
Aneurysm of the first part of the Transverse Arch of the Aorta.

Besides the pain the patient may complain of at the site of the aneurysm itself, the latter will very often bulge sufficiently upwards to interfere with the lower branches of the brachial plexus, and it is not an uncommon thing to find such a patient complaining of very severe pains in his right shoulder region and in the right upper arm, even radiating from thence down the ulnar side of his forearm to his right little and ring fingers. In some cases the interference with the brachial plexus may be so considerable that the muscles supplied from the lower branches of it atrophy, and from the severity of the pain, and the consequent sleepless nights, the patient's health often suffers much more from this aneurysm than it does from one closer to the aortic valves.

One would not expect from this aneurysm any stenosis of the œsophagus, nor any interference with the recurrent laryngeal nerve on the left side; vocal cord paralysis is therefore very unusual, but in rare instances the aneurysm bulges up sufficiently into the neck to interfere with the right recurrent laryngeal nerve where it passes round the right subclavian artery, and then right vocal cord paralysis results. In such a case, however, the diagnosis would be easy because there would be a pulsatile tumour in the root of the neck on the right side.

When the aneurysm extends further along the transverse arch it is sometimes possible to depress the fingers into the supra-sternal notch to palpate a pulsatile mass here.

The vertebræ are seldom eroded by an aneurysm in this position, so that pain in the back is not commonly complained of.



Type 3.
Aneurysm of the distal part of the Arch of the Aorta.

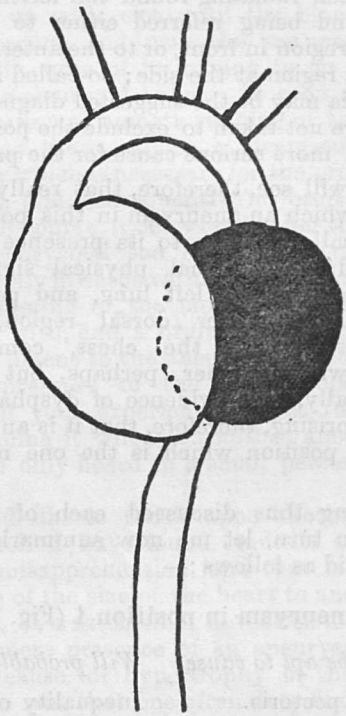
Type 3. (Fig. 3).—*Aneurysm involving the distal half of the arch of the aorta in the part corresponding roughly with the origin of the left subclavian artery.*

The transverse arch of the aorta turns backwards almost more than it does to the left, so that an aneurysm in this third position seldom gives rise to an expansile

tumour that can be felt, unless the aneurysm is simply huge. I have seen such huge aneurysms in this position giving rise to pulsation to the left of the sternum in the upper part of the chest, but to get a tumour with expansile pulsation here is rare. On the other hand, the pressure signs are numerous. It is from an aneurysm in this position that one expects to find paralysis of the left recurrent laryngeal nerve and consequent paralysis of the left vocal cord; it also tends to interfere with the left cervical sympathetic, and so cause inequality of the pupils, the left pupil being either much smaller or much larger than the right. There will also tend to be ptosis of the left upper eyelid. When the origin of the left subclavian artery is involved, the left radial pulse will tend to be delayed behind the right, or to be absolutely smaller in volume than the right. There may be pain radiating down the left arm from interference with the lower branches of the left brachial plexus, but more commonly the aneurysm erodes the vertebræ, and the main site of pain is, consequently, in the upper part of the left side of the back, radiating perhaps to any of the branches of the upper intercostal nerves. The aneurysm is apt to interfere with the left upper bronchus, so that one looks for impairment of note, vesicular murmur, and voice sounds, together perhaps with crepitations in the left upper lobe, and phthisis may be simulated here, and it is possible for the aneurysm to stenose the oesophagus and cause dysphagia, simulating epithelioma of the oesophagus. It is an aneurysm in this position, therefore, which causes a maximum of pressure signs without a pulsatile tumour. It may even cause tracheal tugging, though, as a rule, the aneurysm is too much to the left to make this a prominent sign. So close together are the main bronchi at the bifurcation of the trachea that, although the aneurysm is to the left, some irregular dilatation of it may cause interference with the right bronchus as well as, or instead of, the left, so that abnormal lung signs on the right side may be present. Almost the only pressure signs associated with aneurysm which this particular one does not produce are those connected with interference with the superior vena cava.

Type 4. (Fig. 4).—*Aneurysm arising from the descending thoracic aorta beyond the level of the left sub-clavian artery.*

This, the last of the four types into which I have divided thoracic aortic aneurysms, is one of the hardest to recognise clinically without the assistance of accessory diagnostic means such as the use of the x-rays. The aneurysm is too far down the aorta to cause inequality of the pulses, paralysis of either vocal cord, inequality of the pupils, interference with the superior vena cava, tracheal tugging; and it is too deep seated—unless the aneurysm is huge—to cause any pulsatile tumour. If you will think of it, almost the only pressure signs that an aneurysm in this position can produce are those which result from (*a*) interference with the vertebræ and intercostal nerves; (*b*) from partial stenosis of the lower left main bronchus; and (*c*) interference with the œsophagus.



TYPE 4.

ANEURYSM OF THE DESCENDING THORACIC AORTA.

Stenosis of the œsophagus by an aneurysm is far from common, for the œsophagus is a mobile tube which may be displaced far from its normal site without necessarily being obstructed; but when an aneurysm of the descending thoracic aorta stenoses the œsophagus as it may do, then epithelioma may be simulated closely, and it is on this account that one should be so careful in excluding this difficult type of aneurysm before passing bougies or other instruments in cases of supposed epithelioma of the œsophagus.

Interference with the left lower bronchus will cause impairment of note over the left lower lobe, coughing and perhaps rales, and the patient may be suspected of having pleurisy or some fibrosis of the lower lobe from former pleurisy; the lung signs attracting so much attention that the possibility of aneurysm obstructing a bronchus may not occur to one. One cannot emphasize too much the need for x-ray examination of the chest in all chronic lung cases.

Interference with the bodies of the vertebræ and the intercostal nerves between them on the left side will cause severe pain in the back, generally in the mid or lower dorsal region, this pain often radiating round the left side of the chest and being referred either to the lower sternal region in front, or to the anterior or mid-axillary region at the side; so-called intercostal neuralgia may be the suggested diagnosis if full steps are not taken to exclude the possibility of a much more serious cause for the pains.

You will see, therefore, that really the only things which an aneurysm in this position will do to call attention to its presence are, first, to produce abnormal physical signs in the lower lobe of the left lung, and pain in the left mid or lower dorsal region, and in the left side of the chest, comparatively low down; together, perhaps, but only exceptionally, with evidence of dysphagia. It is not surprising, therefore, that it is an aneurysm in this position which is the one most often missed.

Having thus discussed each of the main types in turn, let me now summarise what I have said as follows :—

An aneurysm in position 1 (Fig. 1)

Will be apt to cause	*Will probably not cause*
Angina pectoris.	Inequality of radial pulses.
Partial stenosis of the superior vena cava	Inequality of pupils.
Impairment of note in 2nd right intercostal space.	Pain down right arm.
Expansile pulsation and perhaps tumour in 2nd right intercostal space.	Tracheal tugging.
Pain to the right of upper part of sternum.	Ptosis.
Abnormal physical signs in right upper lobe.	Vocal cord paralysis.
	Stenosis of œsophagus.
	Pain in the back.
	Palpable pulsation on deep palpation in supra-sternal notch.

An aneurysm in position 2 (Fig. 2)

Will be apt to cause	*Will probably not cause*
Angina pectoris.	Stenosis of the œsophagus.
Partial stenosis of the superior vena cava.	Pain in the back.
Impairment of note in 2nd right intercostal space.	Vocal cord paralysis (though rarely the right vocal cord may be paralysed if the aneurysm is large).
Expansile pulsation and perhaps tumour in 2nd right intercostal space.	
Pain to the right of upper part of sternum.	
Abnormal physical signs in right upper lobe.	
Right radial pulse smaller than left or delayed behind left.	
Pain down right arm.	
Tracheal tugging.	
Palpable pulsation on deep palpation in supra-sternal notch.	
Possibly inequality of the pupils.	
Right-sided ptosis.	

An aneurysm in position 3 (Fig. 3)

Will be apt to cause	*Will probably not cause*
Pain in upper part of the dorsal region of the back.	Interference with superior vena cava.
Pain down left arm.	Tumour dull to percussion with expansile pulsation (unless aneurysm huge).
Paralysis of left vocal cord.	Pain down right arm.
Left-sided cervical sympathetic paralysis.	
Inequality of pupils.	
Ptosis on left side.	
Stenosis of œsophagus, rarely.	
Tracheal tugging, rarely.	
Left pulse delayed behind or smaller than right.	
Interference with one or other bronchus with impaired note over corresponding lung.	

An Aneurysm in position 4 (Fig. 4)

Will be apt to cause	*Will probably not cause*
Pain in the back, especially in mid-dorsal or lower sternal region radiating like intercostal neuralgia round right side of chest.	Tumour dull to percussion with expansile pulsation.
Interference with left lower bronchus with abnormal physical signs in lower lobe of left lung.	Inequality of radial pulses.
Stenosis of the œsophagus, rarely.	Unequal pupils.
	Ptosis.
	Vocal cord paralysis.
	Stenosis of superior vena cava.
	Pain down left arm.
	Pain down right arm.
	Tracheal tugging.

It is, of course, not very uncommon for the same patient to have two aneurysms, and that he has two may sometimes be obvious from the clinical signs, even without an x-ray examination to confirm it. For instance, if there is a pulsatile tumour with impaired note to the right of the upper part of the sternum, and at the same time paralysis of the left vocal cord with a left radial pulse smaller than the right, it is practically certain that the patient has not only an aneurysm of the first part of the aorta, but also one of the distal part of the arch as well; and so on in other cases.

Now let me say a word or two upon a point I mentioned earlier, namely, the relationship of bruits to aneurysms.

I find that most students are afraid to diagnose aneurysm unless there is a bruit, as though they thought that a bruit was an almost essential concomitant of aneurysm. This, however, is so far from being the case that I would even go so far as to say that it is exceptional rather than the rule to find a bruit over an aneurysm, or, at any rate, a bruit that is actually caused by the aneurysm. Very often, of course, the syphilis which has produced the aneurysm has also affected the aortic valves, and therefore one very often has a typical to-and-fro bruit of aortic regurgitation with some stenosis in the same patient who has an aneurysm; or, again, there may be myocardial changes in the heart, with a systolic bruit resulting from changes in the cavities and their relationship to the size of the valves. These bruits, however, are merely associated with, not caused by, the aneurysm; they are due to an associated syphilitic change other than the aneurysm; and I think you will understand that an aneurysm does not, as a rule, produce a bruit if you think that a bruit, for its occurrence, depends upon vibrations caused by the blood not running smoothly through the passages that it has to traverse. If one were to produce an aneurysm suddenly there would at that time almost certainly be a bruit over it, for the blood would eddy and swirl in some part of the aneurysmal sac, and this eddying and swirling would produce vibrations that would be audible as a bruit. If, however, this aneurysm were to remain more or less of the same size for a while, in the very places where there was the most eddy and swirl, there would be a tendency for deposition of blood-clot, so that the uneven parts of the aneurysmal sac would be, as it were, plastered up with clot until the blood in its transit through and past the sac would run smoothly in spite of its having to go through or past the abnormal bulge. As soon as there is a restoration to smooth running of the blood in this way there will be a disappearance of that factor which is necessary for the production of a bruit, and, consequently, no bruit will be heard. Of course, if one were to alter the shape of the aneurysmal sac by pressing its outer surface firmly inwards with the stethoscope, the smooth running of the blood would again be interfered with, and a bruit would result; but when one listens to the aneurysm without such physical pressure of the stethoscope being applied—if your experience proves to be the same as mine it will tell you that aneurysmal bruits are only heard in a small percentage of the cases.

I should like to touch upon another point upon which I have found students are often under a misapprehension, and that is the relationship of the size of the heart to aneurysms in general. It is astonishing how often men think that the mere presence of an aneurysm is an adequate cause for hypertrophy of the heart. It is quite true that one often does find a large heart in a patient who has an aortic aneurysm, but this enlargement is nearly always due to associated syphilitic changes in the muscle of the heart, or to syphilitic aortic regurgitation which may be associated with the aneurysm, or, again, to the effects of the hard physical work that the patient has undertaken in the years preceding the development of the aneurysm, but such hypertrophy is in no way an essential result of the aneurysm itself. Once the heart has pumped its blood through the aorta and valves it matters little to the heart itself whether the blood traverses a normal-sized aorta or an aorta with a bulge upon it. The aneurysm, if it does not itself cause aortic regurgitation, does

not throw any extra work upon the heart, and, therefore, when a big heart is found in a person who has an aortic aneurysm one must realise that some other factor than the aneurysm itself must be thought of to account for this hypertrophy; contrariwise, it is no bar to a diagnosis of even a large aortic aneurysm to find that the patient's cardiac impulse is in its normal position.

(To be continued.)

Some Experiences in Brussels during the War.

BY AN OLD GUY'S MAN.

I.—BEFORE THE GERMAN OCCUPATION.

WHATEVER grounds there may have been from a military point of view for Germany's assertion that Belgium had been secretly preparing for the conflict for many years, it certainly did not apply to their army medical preparations.

What I saw of their field ambulance at the commencement could only be described as inadequate, and with the exception of the "Hôpital Militaire," base hospitals in and around Brussels were practically non-existent. As for the civil hospitals, St. Pierre and St. Jean, they were at that time undergoing a much-needed metamorphosis and were quite unfitted for the accommodation of wounded soldiers.

But the Belgians are a wonderful people and capable of rising to every occasion. Witness their mobilisation and their heroic resistance against an overwhelming horde of invaders; and, judging from the stories we heard first-hand from the wounded prisoners, no one was more astonished than the Germans.

We underwent one or two days of wild excitement, during which all Brussels enjoyed itself flag waving, hunting possible spies—too many of them were the real article—cheering impossible bulletins and buying special editions twenty times a day.

Waste newspaper was at a discount in those days, but before I bid adieu to Brussels all journalism, local and foreign, had been suppressed, save for the German inspired publications, and one had to carry one's purchases home in a string bag or provide one's own wrapping. As for fire-lighting material, two sticks of wood and a few old letters were quite a princely extravagance. My cook had a cherished brown paper bag which used to accompany her every morning to market until the bottom fell out of it from overwork. The loss was irreparable.

Some of the spy-hunts were quite amusing, and led to many comic incidents.

One night a worthy citizen of the Rue Malibran took a stroll on his roof in search of a hammer which he had forgotten after doing some repairs. A passer-by noticed him and called out "espion." The "Guard Civic" was summoned, and they treated him to "five rounds rapid" without killing anything but a few chimney-pots and some tiles. Then a fire escape appeared and was placed in position. The innocent roof walker was hauled down, and, after explaining himself to the crowd, retired into his house.

On another occasion, when a party of German agents in a motor car and provided with forged papers were attempting to enter the town, I started out at midnight with a party of "chasseurs a cheval" in a motor car to the cross roads on the Avenue de Tenneren. Our duty was to hold up every incoming car and examine their papers. We had instructions to fire on any one who refused to bail up at the second challenge.

Two of the party went forward to stop the cars and examine the occupants, a third was at the wheel with his foot on the throttle ready to "let her go" in the event of a chase, and the fourth stood in the back of the car with his rifle at the present. I fancy he was rather over eager, and I felt the muzzle of his rifle tickling my ear first on one side and then the other. At 3 o'clock a.m. I grew weary of speculating as to which side of my head would be blown off first, and I went home.

I heard next day that their only bag was a Belgian official who was hurrying into town with important despatches. They arrested him and kept him cooling his heels in the road until someone arrived from Brussels to identify him.

When we had cheered the latest departing reservist and torn the entrails out of the last German café, we woke to the realization that we were at war and there would be wounded men—many wounded men. So the citizens of Brussels set to work to provide the necessary accommodation, and ambulances and auxilliary hospitals sprang up in nearly every street. Everybody contributed beds, bedding, and linen, down to their last sheet.

Some of the larger buildings were taken over by the municipality, including many banks and hotels, also the vast Palais de Justice, closed to their ordinary business. The Queen of the Belgians, who has always the welfare of the sick and wounded at heart, converted the Royal Palace into an ambulance. At the end of the week we had over a thousand beds fully equipped, nor was there any lack of "ambulanciers" and "infirmierès." Everyone was anxious to "do their bit," and the "brassard" with the Geneva cross was the only fashionable wear.

This led to a grave abuse. Many persons whose nationality and motives were not above suspicion used the badge as a means of entrèe to places otherwise forbidden to them, and there is no doubt that much harm was done in this way.

This was quickly recognised by the authorities, and a Red Cross committee was organized which speedily

suppressed the unauthorised and fraudulent wearers of the badge. To obtain permission it was necessary to produce a "carte d'identité," with which every Belgian is provided almost from birth, and a certificate of good conduct signed by the police of one's commune. Fortunately it is almost impossible to falsify these papers in Belgium.

The Red Cross committee visited and inspected all private ambulances and registered the number of beds properly equipped, the quantity of hospital stores and appliances, and the number and names of the attendants. They also collected all drugs and dressings, and placed them under such strict control that it was difficult to obtain anything without a prescription approved and stamped by the committee.

Some of these private ambulances were splendidly equipped with every necessity. Quite a number of them boasted X-ray installations, and most of them had their own motor ambulances.

The one thing lacking was a proper complement of medical men. Many of them were attached to the army and departed with it, and a large proportion of the residue volunteered for service at the commencement, so that some of the ambulances were obliged to close their doors, and the survivors were reduced to sharing the services of one surgeon between three or four of them.

I had been practising in Brussels some six years before the outbreak of the war, and together with several of my Belgian colleagues I offered my services in the capacity of dental surgeon. They were accepted at once, and I was attached to one of the larger ambulances. At first our duties were not arduous, as the early casualties were mostly from exhaustion and a few minor wounds.

Everyone who has read the story of Liège will realise how splendid these fellows were. They had fought and toiled in the broiling sun until they dropped, and they considered it hard indeed that they should be sent away with scarcely a scratch. Their one cry was that we should get them on their feet as quickly as possible so that they might return to the fighting line.

The Belgian soldier is not addicted to boasting, and from the accounts they gave us of the attack on the forts at Liège the German losses must have been terrific. There was no trench fighting. The Germans, who had not yet brought up their heavy artillery, sought to overwhelm the garrisons by force of masses which advanced up the "glacis" shoulder to shoulder, and the Belgian guns were firing into them point blank. After two days of slaughter the Germans were obliged to ask for a twenty-four hours' truce to enable them to collect their wounded, and there is no doubt that they misused this truce to bring up their heavy guns which they had found hitherto impossible owing to the accuracy of the Belgian fire which destroyed their pontoons as soon as they were erected. After the fall of Liège the real "wrack of battle" commenced to arrive, first in twos and threes, then in dozens.

Very few of us had ever seen a gun-shot wound, and the damage caused by modern projectiles under modern conditions of warfare completely upset our preconceived ideas. We had always understood that the modern bullet caused a clean puncture and the only complication existed in sepsis from fragments of clothing, etc., carried in by the projectile. This may be so at the actual time of occurrence, but whether due to the German habit of splitting the nickel case of the bullet (for this I can vouch) or to the long journey from the front, the nature of the wounds was appalling.

This, however, had one beneficial effect. It weeded out the weak members of our ambulance staff, many of whom attracted rather by the importance of wearing the "brassard" than the actual work, dropped out after the first few days of the real thing, so that the English Red Cross contingent, which arrived about this time, was thoroughly welcome.

We derived a good deal of amusement from the various rumours circulated in the town. The British fleet was reported off Antwerp. No one stopped to consider how they got there without violating Dutch neutrality; we simply cheered ourselves hoarse. Then, Kitchener and 20-000 men had landed at Ostend. Wild enthusiasm. Anyone suspected of British nationality was hoisted shoulder high by the crowd and thumped and back-patted until he regretted that he had come out without a beard and detachable cuffs.

Occasionally a "Taube" passed overhead, and the Guard Civic potted at it from every side. I have often wondered where the bullets came to rest, certainly not within hundreds of yards of the Taube, which was always flying at a safe height.

One night the entire population of the Quartier Ixelles turned out to view a certain mysterious bright light in the sky. Was it a Zeppelin? No; it was poor old Venus. I did not know that she was addicted to migratory habits, but my neighbours in the crowd assured me that it was quite in another quarter when first sighted.

Soon we were at work in grim earnest. The hospital trains were arriving all day and the overflow of casualties began to reach the private ambulances. When each train was due to arrive, collecting parties were sent from the hospitals to the Schaerbeck Station where a staff of surgeons and nurses were busy sorting out and classifying the casualties. As each party received its cases in accordance with the acmodation and class of institution it represented, the stretchers were packed on the motor ambulances and taken away at once. The graver cases were placed on the trams and taken directly to the doors of the larger hospitals.

These improvised motor ambulances are quite worthy of description. They were ordinary private cars from which the body had been removed and replaced by a flat wooden stage accommodating four or six stretchers placed side by side latitudinally. This was surmounted by a wooden frame supporting a roof and sides of brown canvas. They were sanitary and practical. To charge them it was only necessary to loop up the canvas side and slide the stretcher into the grooves provided for it, where it was secured by an iron staple. Any one stretcher could be removed without disturbing the others, and from either side of the vehicles.

We saw the first shrapnel wounds, and they were terrible. Owing to the direction of the shrapnel burst, downwards and forwards, the majority of the wounds were in the head and shoulders, and a large percentage of these men were suffering from shattered jaws. Indeed, it was no uncommon thing to find teeth imbedded in a man's shoulders and neck. There were many fine opportunities for orthoplastic work if we had only had the time.

I must remark here that, in spite of the handicapped condition of the field ambulances, the first dressings were made with the utmost care, and the majority of cases arrived in better condition than we anticipated: a marked contrast to the German treatment of their wounded as I will point out later on.

Most of our patients were Belgians, with a sprinkling of Frenchmen and an occasional Englishman. There was a goodly number of wounded prisoners, chiefly Bavarians, but they were treated in special ambulances. Much has been written about the brutality of the Bavarians, but my personal belief is that most of the terrible atrocities in Belgium ascribed to these troops were committed by the Prussians. Many of these men were quite ignorant of the fact that they were fighting the Belgians, and it was difficult to make the wounded prisoners believe that they were actually in Brussels, their officers having told them that they were advancing on Paris.

It is a fact that early in the German occupation of Brussels the Bavarians came to blows with the Prussians because the latter had grossly insulted the statue of the Belgian Queen. After this occurrence the Bavarians were disarmed and sent out of the town.

It is also a fact that some of these men had been shot in the back by their own officers, and many bore the unmistakable evidences of having been flogged. Among our patients we had several victims of German brutality. Their injuries were horrible, and some of the accounts they gave us of their treatment are too abominable for repetition. A large section of the English public is inclined to consider these tales as "press" stories. I can assure them that, far from being exaggerated, not one third of the horrors will ever be recounted.

The first intimation we received that Brussels was in danger of invasion was from a notice posted by the gallant M. Max, warning the civil population not to resist in case of the entry of German troops, and suggesting that it would be better to hand over all the firearms to the communal authorities so that the enemy should not have an excuse for reprisals such as they meted out to other towns. All the main roads into the town had been put in a state of defence with trenches, barbed wire, and overturned tram cars. I do not think this was done with any idea of resistance to an attack in force, but more as a precaution against the incursion of bands of Uhlans who were raiding the country side in advance of the army and destroying life and property without mercy.

At last, on the 20th August, and late in the evening, we received notice that there would be no further resistance and the German troops would be passing through the town on the morrow. It was an unforgettable night for us at the ambulances. We were given just five hours to clear out all our patients, such as could be moved, and entrain them for Ghent and Ostend. No praise can be too high for our "ambulanciers" at this crisis. The order was unexpected, and we were quite unprepared. Had it not been for the prompt generosity of the inhabitants who lent us every vehicle and motor car available, and for the fact that everyone did the work of three, it would have been impossible to comply with the order. As it happened, we had all our charges safely transported to the station well within the given time.

It would be difficult to adequately describe the chaos which reigned at the North Station where we entrained. It was one mass of troops, baggage, stores and wounded from every hospital in the town, with their attendant "ambulanciers." To add to the confusion, many of the inhabitants had become panicky and were arriving at the station in thousands, all anxious to get away from the town before the arrival of the dreaded Germans. These people crowded into every train and truck, and we had literally to fight them out of the hospital trains to make room for our wounded. Eventually they were persuaded that there was really nothing to fear from the incoming enemy, and many returned to their homes.

It was well into the early morning before the last train left the station and we returned to the deserted ambulances, and by breakfast time the appearance of the town seemed almost normal. I believe that many of the townsmen knew nothing of what had occurred in the night until they read it in the morning papers, the very last edition of the ordinary journals published in Brussels.

Of the unmovable wounded left to fall into the hands of the Germans I cannot give the exact number, but I do not think it exceeded fifty. I afterwards learned that some of the minor cases who were too late to entrain were taken into private houses where they became for the time being secretaries, butlers, etc.

Nursing News.

MATRON'S OFFICE,
2nd June, 1915.

On Sunday last a number of nurses from New Zealand visited Guy's and were very interested in all they saw, including a visit to the Museum. They are on their way to Egypt.

On Wednesday Mr. and Mrs. Freshfield and Matron are entertaining a party of 30 Canadian nurses to tea in the Home, and they are afterwards to inspect the Hospital.

Miss Gwilliam, Guy's Institution, who went out under the Joint Committee in October, 1914, writes from Wimereux:—"We have been very busy lately with very badly wounded patients. We have only been able to keep them a very short time, perhaps just a day, because beds are so badly needed, patients lying on stretchers waiting for them.

"Sir Victor Horsley was here for six weeks, and a very strenuous time it was. I believe he is now in the Dardanelles.

"This is a delightful little village and the sands are beautiful; later we expect to enjoy the bathing, at present it is too cold. There are many Guy's here."

Miss Mallandaine, who has been for some years at the Mission Hospital, Kwa Magwaza, Zululand, and is now nursing in France, writes:—

—— Hospital,
British Expeditionary Force,
May 22nd, 1915.

"The capacity of this hospital is about 500 beds. I have been in various wards, including the cerebro-spinal meningitis ward, which I can only compare to the infernal regions, the disease is so diabolical, and most distressing to nurse; no two cases are quite alike, and they are all more or less mental. They say fifty per cent. recover, but many acute cases were brought in unconscious and died within 12 or 24 hours, and others less acute at first, became so, or else got gradually worse. The recoveries were moved into a convalescent ward, and they often relapsed and came back. We have very little equipment here for real nursing. Only last night I had a head case with a nasty wound lying on a pillow that the others had nicknamed "sand-bag," such was its shape and hardness. However, I crept round and found a private air cushion which I annexed for the night, and soon had the joy of seeing sleep descend on the troubled bed.

"I should like every man and woman in England to stay two nights in our wards. We should then hear nothing more of strikes, drink, and racing. If only those at home could see and hear; the Tommies are splendid patients, but how they suffer! It is awful."

From No. 18 General Hospital, Misses Dorothy King, Strutt, and Mackenzie write:—"This hospital, under canvas, is in a very nice position on a hill, with a view of the sea in the distance. Sister Martin is here, an ex-Guy, and I have seen two or three others with our badge, but I do not know their names yet.

"The men never grumble or complain, and they have most awful wounds, and tell one dreadful stories of their life in the trenches. There are about forty-eight patients in each ward, and one may have three wards to look after at night.

"Making beds here is very back-aching work, as the beds are so low. We work from 8 p.m. to 8 a.m., and the day nurses from 7.30 to 8 p.m."

Misses Squire, Orchard, and M. Roussiano write from Rawal Pindi, Brit. General Hospital, Wimereux, and the extension "La Plage":—"Time passes so quickly that it seems hardly possible we have been nearly five months here. We shall be very sorry when the time comes for us to separate, as we have been happy together, and when off duty had some lovely walks in the country."

Miss Orchard says:—"I had charge of the first floor and a nursing orderly to help. There are forty-two beds, three beds in each room. The rooms were very confusing at first, but one quickly gets used to them. The patients are nearly all surgical stretcher cases. The staircase fortunately is wide, as there is no lift, and the patients have to be carried up and down to the theatre.

"On day duty there is one other sister who is in charge and myself, with a V.A.D. helper part of the day. There is always plenty to do, but except when there are "rushes" we get two hours off each day and meal times.

"We have plenty of clothes for the patients, and the food for them is very good. We get the daily papers on the day of publication, and they are given out to the patients. The Tommies are just splendid (I expect you hear that from all the nurses); I am never tired of admiring their pluck.

"Mr. Seabrooke is here. He is M.O. for the Hospital for Officers which the Rawal Pindi has started at a chateau near. There are sixty beds, and everything is very nice indeed. Major Davis-Colley is the surgeon for both hospitals."

Miss Roussiano says:—"My ward consists of two corridors and the bedrooms have three or five beds in each, 77 beds in all. Often we have camp beds put up in the corridors and also in some of the larger rooms."

Notice.

His Majesty's Indian Medical Service.

A Competitive Examination for not less than ten appointments to His Majesty's Indian Medical Service will be held at the Examination Hall, Queen Square, Bloomsbury, on the 12th July, 1915, and five following days.

Copies of Regulations for the examination, together with information regarding the pay, retired pay, etc., of Indian Medical Officers, can be obtained on application to the Military Secretary, India Office, London, S. W. Application for admission to the examination, with the necessary certificates, must be sent so as to reach him on or before the 30th June, 1915.

No candidate who would have been eligible if an examination had been held in ordinary course in January last will be excluded from the July examination, *i.e.*, candidates must be between 21 and 28½ years of age on 1st August, 1915.

PROGRAMME OF EXAMINATION.

EXAMINERS:

Hector Mackenzie, Esq., M.A., M.D., F.R.C.P., in Medicine and Therapeutics.

Sir W. Watson Cheyne, Bart., C.B., P.R.C.S. Eng., in Surgery and Diseases of the Eye.

Professor R. W. Reid, M.D., F.R.C.S., in Applied Anatomy and Physiology.

Professor J. Lorrain-Smith, M.A., M.D., F.R.S. Edin., in Pathology and Bacteriology.

Professor F. W. Kidd, B.A., M.D., etc., in Midwifery, Diseases of Women and Children.

Professor Sir William Whitla, M.A., M.D., LL.D., in Materia Medica, Pharmacology, and Toxicology.

AT THE EXAMINATION HALL.

Monday, 12th *July*, 1915.

Practical Pathology, from 2.30 p.m.

Tuesday, 13*th July*, 1915.

Clinical Medicine and Examination of Specimens* from 10 a.m.

Paper in Medicine and Therapeutics, from 2 to 4 p.m.

Paper in Surgery and Diseases of the Eye, from 4.30 to 6.30 p.m.

Wednesday, 14*th July*, 1915.

Clinical Surgery, from 10 a.m.

Paper in Pathology and Bacteriology, from 2 to 4 p.m.

Paper in Applied Anatomy and Physiology, from 4.30 to 6.30 p.m.

Thursday, 15*th July*, 1915.

Clinical Surgery, from 10 a.m.

Paper in Materia Medica, Pharmacology, and Toxicology, from 2 to 4 p.m.

Paper in Midwifery, Diseases of Women and Children, from 4.30 to 6.30 p.m.

Friday, 16*th July*, 1915.

Surgical Operations, from 9.30 a.m.

Oral Examination (half of the candidates), from 2.30 p.m.

Saturday, 17*th July*, 1915.

Oral Examination (remainder of the Candidates), from 9.30 a.m.

Examiners to meet in conference on termination of the examination.

*Candidates will be required to examine and report in writing upon microscopic and macroscopic specimens to be presented by the Examiners in Medicine, Surgery, Physiology ,and Pathology. The reports will be made on forms supplied for the purpose, and one hour will be allowed for the four reports.

ALLOTMENT OF MARKS.

(1.)—In Medicine and Therapeutics.

Paper ...	600
Clinical	300
Oral ...	300
Total	1,200

(2.)—In Surgery and Eye Diseases.

Paper ...	400
Clinical	400
Oral ...	200
Operations	200
Total	1,200

(3.)—In Pathology and Bacteriology.

Paper ...	300
Practical	350
Oral ...	250
Total	900

(4) (5.)—In Materia Medica, Pharmacology and Toxicology, and in Midwifery and Diseases of Women and Children.

Paper ...	400
Oral ...	200
Total in each of the two subjects	600

(6.)—In Anatomy, etc.

Paper ...	350
Oral ...	250
Total	600

To qualify, Candidates must obtain at least one-third of the total number of marks allotted in each subject, and one-half of the aggregate marks for all subjects.

EDMUND G. BARROW,
General,
Military Secretary.

India Office, Whitehall, S.W.
April, 1915.

Death.

BLIGH.—Fell in action, near Fromelle, France, on May 9th, Eric Bligh, of Christ's College, Cambridge, and 2nd Lieut., 3rd Batt. East Lancashire Regiment, aged 20 years, the only son of William Bligh, M.D. Lond., and of Lilian Josephine, *née* Lafone, once Sister Astley Cooper.

"Ante diem perüt,
Sed miles, sed pro Patria."

W. E. T.

GUY'S HOSPITAL GAZETTE.

VOL. XXIX., No. 704.] JUNE 19, 1915. [SIXPENCE.

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Passim.

IN the abstract it is easy to be philosophical, to hold that it is foolish to regret and deplore the loss of a good life, well lived and bravely sacrificed for a sufficient cause.

Rationally, such a loss should be a source of pride, but human nature is so constituted that those very qualities in our fallen friends which should make us rejoice in the manner of their life and death, also kindle an affection which makes their loss an overwhelming sorrow.

It is for this reason that all who knew A. C. Clifford and J. E. Rhys Evans must deeply mourn for them.

Guy's men who had the privilege of knowing A. C. Clifford at Cambridge valued him as an earnest man and a pleasant companion, but it was not until the Hospital developed new points in his character that his exceptional qualities became apparent.

He entered the Hospital in 1910, having previously been educated at Marlborough and Emmanuel College, Cambridge. As a student at Guy's he went through his appointments with an unobtrusive efficiency which was very characteristic; but though his work was done with thoroughness, he found time to occupy himself with other than technical matters, and he gradually formed for himself clearly defined and firm opinions on a variety of subjects.

In 1913, he took his finals at Cambridge, and then went through all the House appointments, ending as Dr. Hale White's House Physician, and President of the Residents.

It was obvious that responsible work at the Hospital made him a calm, capable man, whose earnestness was certain, sooner or later, to bring him to eminence. At the beginning of the war he was mobilised with the Territorial Cavalry Regiment to which he had belonged when at Cambridge. He did not transfer to the R.A.M.C., but fought as a combatant officer in charge of a machine gun section with the 3rd Dragoon Guards, and was killed at Ypres on June 1st, 1915. His brother writes :—

> "You will be glad to hear that death was instantaneous. We have had some kind letters from his brother officers. He was using his medical knowledge in looking after the wounded in the trenches. . . . .
>
> "His adjutant writes that he showed a splendid example of pluck and died a brave soldier's death. He was working his gun like an old hand and enjoying it all. His body was taken back from the trenches and buried in the little village churchyard at Vlamerfinhe."

Mr. J. E. Rhys Evans, of whom we hope to publish a portrait and obituary notice in the next GAZETTE, entered the Dental School in May, 1908, for the Clinical Course of Instruction, after having completed the two years' apprenticeship in Mechanical Dentistry. He left Guy's after obtaining tho L.D.S. in November, 1912. He was a thorough all-round sportsman, and kept goal for the first Soccer eleven for several

seasons. He gave his life for our Country in the Dardanelles at the early age of twenty-seven. We sympathise most deeply with the families of these gallant gentlemen, but try to console ourselves by considering that, although the relentless necessity for the present sacrifice has cut short two promising careers, their lives were made complete by the manner of their death. May we ask to be allowed to share the pride that their sorrowing parents must feel.

His Majesty the King has bestowed the Distinguished Service Order on Lieut.-Col. C. R. Evans, R.A.M.C., an old Guy's man.

Lieut. G. F. Hardy informs us that a Guy's man believed to be Lieut. H. C. Godding, R.A.M.C., was mentioned by Eye Witness in his account of the recent battles in France.

According to a private letter received last week, the wound which Surgeon E. G. Schlesinger sustained to his right hand is improving. "He has been mentioned twice in dispatches for bravery, and gained affection and admiration from every man with whom he has come in contact."

We regret to hear that Surgeon Rolf Creasy has been wounded twice during the recent fighting in the Dardanelles. There is an unconfirmed rumour that C. Sherris and F. Augustus Lowe have been killed in action.

The suggestion that Medical and Dental Students should wear badges to show they are exempt from military service has raised a storm of opposition from many readers of the Gazette.

As the result of the correspondence on this subject, the very practical suggestion has been made that as many men as possible should give up their summer vacation and devote their time to making munitions of war; fifty or a hundred men could do quite a lot of useful work in six weeks. Will men who are willing to give their services kindly leave their names at the Medical School Office, and, if a sufficient number of men are enrolled, the Dean will make an official offer to the War Office.

In order to lessen the inconvenience caused by the shortage of anæsthetists, Mr. Rowell has consented to give anæsthetics for the taking in surgeon on alternate Tuesdays. On the other Tuesday, Mr. Rowell or Mr. Page will come, if they can, when telephoned for.

Since the War began, two hundred and fifty officers have been admitted to the Officers' Section, and only twenty-four officers have gone to Convalescent Homes, although there are more than twenty-four Homes to which these patients may be sent.

Another Coolidge tube and apparatus has been installed in the Surgical Skiagraph Department.

EXAMINING BOARD IN ENGLAND

BY THE

ROYAL COLLEGE OF PHYSICIANS OF LONDON

AND THE

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

Examination in Practical Pharmacy.

Notice is hereby given that the Synopsis of the Examination in Practical Pharmacy has been revised in accordance with the new Pharmacopœia, and that the new Synopsis will come into force at the next Examination in July.

Candidates will, however, have the option of being examined on the old Pharmacopœia, at that Examination and also at the Examination in October.

Copies of the new Synopsis may be obtained on application to the Secretary, Examination Hall, 8–11, Queen Street, Bloomsbury, London, W.C.

FREDERIC G. HALLETT,
Secretary.

Appointments.

Civil.

The following have been re-elected Members of the Senate of the London University by the bodies indicated :—

Dr. F. Taylor (Royal College of Physicians of London).

Dr. H. L. Eason (Faculty of Medicine).

J. M. Fortescue-Brickdale, M.D., Ch.B. Oxon., has been reappointed Director of the Public Health Laboratory at the Bristol University.

Naval.

G. B. Cockrem to be Surgeon R.N., H.M.S. *Botha*, c/o G.P.O.

Royal Army Medical Corps.

D. H. Trail, M.O., 1/c 3rd Battalion, Duke of Cornwall's L.I., and doing duty at Military Hospital, Falmouth.

Major Charters Symonds, 2nd London General Hospital, has been promoted to Lieut.-Colonel in the R.A.M.C., and has been appointed a Consultant to the Eastern Command (Northern Division).

Alfred Wills to be temporary Lieutenant whilst serving with the British Red Cross Hospital, Netley.

To be tempcrary Lieutenants :—Charles Coventry, J. L. Atkinson, C. Price Jones, W. J. Harris, F. W. Rowland, E. W. Blake, P. H. Berry, H. M. Meyrick Jones.

Lieut-Col. F. E. Fremantle, from Sanitary Service, to be Deputy Assistant Director of Medical Services, East Anglian Division, *vice* Major E. C. Freeman, who vacates the appointment.

1st Lowland Field Ambulance, A. G. Buchanan to be Lieutenant.

1st Southern General Hospital, Major James T. J. Morrison is restored to the establishment.

5th Northern General Hospital:—The undermentioned to be Captain, whose services will be available on mobilisation :—N. I. Spriggs.

2nd Western General Hospital :—Harry Platt to be Captain, whose services will be available on mobilisation.

F. J. Wheeler, Lieut. R.A.M.C., M.O., 1/c 16th Batt. The King's Liverpool Regiment, Hoylake, Cheshire.

Indian Medical Service.

To be Captain :—Lieut. G. B. Harland, I.M.S.

Attached to other than Medical Units.

S. A. Withers, 2nd Lieut., 3rd Lancashire Regiment.

P. King, P. A. Tucker, S. J. Peatfield, to be 2nd Lieuts.

V. Steele to be 2nd Lieut., 13th Hampshire Regiment.

Specialities.

"Semprolin" Pretroleum Preparations.

These preparations, manufactured by Messrs. William Browning & Co., 4, Lambeth Palace Road, S.E., present petroleum of the density most suitable for internal use, in its purest form, and specially filtered and refined.

"Semprolin" Emulsion, the chief preparation of the series, contains 60 per cent. of liquid paraffin, almost double the amount present in the average petroleum emulsion. It is very palatable and acceptable, especially to those who dislike the oiliness and rather slimy after-taste of the plain liquid paraffin. It is free from hypophosphites or other concomitants which limit the dosage.

For all conditions in which liquid paraffin has proved of use, "Semprolin" Emulsion is to be preferred because of its palatability and reliability. A further reason for its employment in preference to the plain oil is that the process of emulsification ensures absorption of a certain amount of the oil upon administration. In the intestinal atony which gives rise to chronic constipation and intestinal stasis, in visceroptosis, in mucous colitis, in enteric, cholera, and inflammatory conditions of the large bowel, it has proved its value in actual practice.

"Semprolin" Emulsion forms an excellent vehicle for the exhibition of other medicaments and a series of useful combinations is issued. In these preparations the liquid paraffin is of value in many ways. Sometimes it is its laxative effect that is of importance, *e.g.*, in "Semprolin" Emulsion with iron or with bismuth; often its cleansing and protective effect on the intestines and its action as an inhibitor of bacterial activity are of value, *e.g.*, in "Semprolin" Emulsion with salol; and always its action as a preventive of intestinal stasis and consequent auto-intoxication is of peculiar significance, *e.g.*, "Semprolin" Emulsion with glycerophosphates in debility.

"Semprolin" Laxative Cream contains 90 per cent. of the purest Russian liquid paraffin. It is a white, "blanc-mange"-like preparation with a delicious taste. Children and fastidious individuals accept it readily. Particular attention is directed to the very large quantity of oil that this preparation contains.

"Semprolin" Cream is an ideal laxative for children and infants, since it possesses none of the crude purgative action of drugs as senna, sulphur, castor-oil, etc., but acts solely as a lubricant. No habit is induced, and competent authorities have fully demonstrated the harmlessness of continued administration of liquid paraffin. Only the finest Russian oil of high specific gravity and absolute purity is used in the manufacture of this cream.

Every ingredient in "Semprolin" preparations is of the finest quality procurable. With the exception of the combinations with malt, none of these preparations contains sugar, and they are, therefore, specially valuable in diabetic conditions. All "Semprolin" preparations keep in good condition practically indefinitely. Samples will be sent to the medical profession on request.

Some Experiences in Brussels during the War.

BY AN OLD GUY'S MAN.

II.—DURING THE GERMAN OCCUPATION.

IT was, perhaps, with the most admirable foresight that the authorities kept the people in ignorance of the imminent occupation of Brussels by the enemy until the last minute; otherwise it might have resulted in a far greater panic than the one I have attempted to describe, which would have seriously hampered the departure of the troops and stores on the previous night.

The official announcement, written in such terms as to cause no alarm, was not posted on the walls until 11 p.m., and by that time most of the citizens were indoors; so that, with the exception of the authorities and those who had passed a strenuous night at the Gare du Nord with the wounded, few of the citizens knew anything about it until the Germans were actually in the outskirts of the town. They accepted the inevitable calmly, for two reasons: firstly, that they had implicit confidence in M. Max; secondly, that it was then too late to bolt.

The Guards civic were withdrawn from their posts at midnight and disbanded. Their arms and accoutrements were collected and sent off by the last trains, and many of the men who had volunteered for active service with the army left also. It was not possible to warn some of the outlying posts in time, and when they returned to town in the morning they were ordered to get rid of their arms as quickly as possible. This they did by throwing them into the lakes at Ixelles, and some of the more nervous inhabitants of the quarter followed suit with everything that could be described as firearms. About 10 o'clock a slight panic occurred in the Place St. Croix. The daily market was in full swing, when some mischievous person gave the alarm that Uhlans were coming down the road from Boitsfort. Instantly the market women seized their offspring and scuttled into the neighbouring houses. But when a few minutes had passed and no Uhlans appeared, they ventured out again, and the market went on as merrily as ever.

It was nearly mid-day before I saw my first German soldier. I was standing in the Rue de la Madelaine in a crowd of people who were evidently awaiting some event. After a few minutes a car came at full speed over the temporary structure which bridges the cutting for the new central station, and whisked round the corner into the Grand Place. It was followed by another and another. I think there were five in all; long, low, business-like cars, painted dull grey, and furnished with that peculiar iron spur which reaches from the starting handle and curves away over the heads of the occupants, and whose purpose is to pick up and cut through any wire cable stretched across its path. Each car contained three or four officers and four soldiers with the rifle at ready.

As each car pulled up in front of the Hotel de Ville the soldiers sprang out, and, fixing bayonets, doubled back to their allotted posts at the entrance to every street leading into the Grand Place. This movement was so admirably executed that one would almost imagine it had been rehearsed many times. These officers were General Sixt von Arnim and his staff on their way to parley with the Burgomaster.

It would be difficult to adequately describe the scene on the Boulevard Botanique. As far as the eye could reach up and down, it was one mass of moving troops, infantry, cavalry, artillery, and transport. It was "kolossal," and I think our sensation was one of admiration rather than fear. They were big men. Not "big" in the sense of the word as we applied it to the troops which occupied Brussels later on; men whose chests had slipped down to obliterate their waistline, but fine men, in the pink of condition, lean, muscular, and burned brown by the August sun.

And their equipment was wonderful. Every strap and buckle in place. Their horses were good. I fancy that many of them had never known Germany, but were requisitioned on the way. The Germans had two ways of "requisitioning." In the first, they took what they wanted and gave a receipt for the alleged value, in some cases "to be paid *after* the war." In the second they simply shot and buried the original owner, and took his goods. The latter method seemed to be the more popular, as it was more economical.

We could not ascertain the exact number of troops that passed through the district, probably about 300,000 to 400,000. They were divided into three columns: one passing through Waterloo, another to the N.W. of Brussels, and the third through the town itself. They were the pick of the German military forces, and we learned afterwards that it was Von Kluck's army on the road to Paris. You can form some idea of its immensity when I tell you that they passed in a never-ending procession during three days and nights.

Occasionally there was a halt, and men and horses bivouacked where they halted. In the large open spaces such as the Place Rogier, opposite the Gare du Nord, the field kitchens were soon at work, and food was distributed up and down the line.

I was fortunate enough to witness one instance of their preparedness. During a short halt an aeroplane suddenly appeared over the buildings. Almost quicker than I can write it, the tarpaulin was stripped off a wagon and up popped a quick-firing gun which was trained on the intruder. But the aeroplane proved to be one of their own aviatiks, and dropped a signal —a string of three white lights. The officers waved it a welcome, and the gun went back to bed as quickly as it came out.

Down the left-hand side of the Boulevard passed a stream of motors containing officers, and it is a significant fact that occasionally a car would break out of the procession and turn down a side street to the officer's *own home*. I wonder if the same thing would occur if ever their forces should invade London.

At that time we had very little to do at the ambulances, so we were able to witness the whole of the three days' procession. All Brussels had turned out to watch the passage of the troops. Their attitude was extraordinary. They regarded it in silence, and save for an occasional comment there was no sound but the clank of accoutrements and the buzzing of the hurrying motors. In fact, it gave one the impression of a vast funeral cortege, and an incongruous note was struck by the hundreds of Belgian flags which fluttered from the houses on every side. Brussels is very well provided with flag-poles; every house boasts of at least one, and from the beginning of the war all loyal citizens displayed the allied colours. Any one who neglected this risked broken windows.

In the poorer quarters some busybody took it upon himself to order in all flags, but this was immediately countermanded by one of M. Max's famous "affiches," stating that "although Belgium was undergoing a temporary invasion, it was still an independent state, and all true Belgians should keep their colours flying and pray for the speedy discomfiture of the invader." Such was the spirit of our Burgomaster. About this time he issued another "affiche" declaring that the troops would be passing through the town for several days, and if the citizens would remain calm and in no way interfere with the soldiers, he had the promise of the German Commander that no harm should befall the inhabitants or their property.

This was posted side by side with an affiche signed by von Armin, the purport of which was similar, but couched in severer terms, and threatening terrible punishment if one of his soldiers should be hurt by the people. Of course, von Armin kept his word in the true German fashion. No sooner had the main body of the troops passed through the town than he installed a garrison. He appropriated the Hotel de Ville as a "Kommandantur" and appointed himself as Governor.

Parties of soldiers started out to requisition food and stores for the troops. I witnessed more than one of these gentle foraging parties at work. They usually consisted of one or more wagons conducted by a non. com. and half a dozen soldiers, with fixed bayonets. When they reached a store which attracted their fancy —the "charcuteries" (anglice, ham and beef shops) were especially dear to them—the officer and some of the men entered and ejected the regular customers, and then proceeded to help themselves to everything they fancied and load it on the wagons. The remainder of the soldiers stood on guard outside to prevent anyone entering until they had finished their "shopping." Of course, they gave a receipt, but it was never for more than half the value of the goods.

One unfortunate peasant from whom the troops had "bought" two pigs appeared at the kommandantur to cash his receipt and received two marks in payment. When the peasant protested that two marks was a very thin price for two fat pigs, the official pointed out that the receipt was for two rabbits. It was written in German, of which the unfortunate man understood nothing, and he was subsequently imprisoned for daring to suggest that a German soldier could be capable of swindling him.

All local newspapers were suppressed, and one had to buy them surreptitiously or go without. Our literary food was supplied by the German Military Government in the form of bulletins written in German and French, and posted out of reach of destructive fingers and pencil comments. I leave you to imagine the wonderful nature of the news thus displayed. Whether they judged the average Belgian's intelligence by their own standard or whether they credited him with none at all, it is a fact that the events recorded in the German column rarely coincided with those in the column printed in French. Some one ventured to point out a more than usually glaring discrepancy to a German officer. He seemed surprised, and answered rather curtly that the bulletins were not intended for us, but for the German soldiery. In spite of the fact that these wonderful posters were "skied," they did not escape pencil commentaries, most of them extremely witty though unsuitable for publication.

But the German imagination won it's spurs over a delightful bulletin stating that the first draft of Kitchener's army had embarked for France, and so incomplete was its equipment that the men lacked bootlaces, handkerchiefs, toilet soap, notepaper and pens and ink; that no fifes or drums could be found for the Scottish regiments and they were obliged to start without them. The "Brusseleers" rocked with laughter and the comments were many and obvious.

Next day the Kommandantur was inundated with anonymous parcels containing old bootlaces, various specimens of paper, etc., and letters begging the Gouvernor to forward these gifts to the unfortunate English troops. The German authorities removed the poster that night. I sincerely hope that someone has obtained a specimen of this famous notice; it is invaluable as an example of the German mentality.

It was about this time that the Kommandantur moved its quarters to the Ministeries, and all that section of the Rue de la Loi from the Rue Ducale to the Rue Royale was closed to the public. They seized the Royal Park and turned it into a cavalry school and parade ground. Its appearance was not improved by galloping horses over the grass plots and flower beds.

We began to suffer from a shortage of provisions, but this was chiefly due to the lack of transport. The Belgian army had taken many of the horses and motors, and one of the first acts of the Germans on entering the town was to commandeer the remainder. Chiefly we lacked flour. Apart from the fact that we had many thousands of extra mouths to feed, the Dutch had placed an embargo on wheat, and the small quantity that managed to get through was promptly annexed and sent off to Germany. In consequence, our daily bread was scant in quantity and of a quality to be sadly remembered. If anyone had cared to make an analysis, it would have proved to have consisted of bran, potato flour, odds and ends of wood, linseed meal and—for several days—no leaven or salt, which was at a premium. Small wonder that there was an epidemic of gastritis.

We were also very short of fuel, for at that period a sanguinary battle was raging round the coal fields at Charleroi. So Brussels had to economise in gas, and as it was almost impossible to obtain paraffin—the Germans had commandeered everything that could be converted into motor spirit — many of the inhabitants had to rely on candles or go to bed when daylight failed.

Those who had known Brussels before the war would not have recognised it as the same town after nightfall. The boulevards were deserted and dark, and by order of the Belgian authorities all cafés were closed at 9 o'clock. One thing, however, was exceedingly cheap. In normal times Belgium exports a large quantity of fruit to England. As there was no longer any means of transport, the growers had to consume it themselves, and it was possible to buy in the street magnificent grapes at 25 centimes the pound.

The moratorium was in operation, and owing to this and the financial panic at the commencement of the war, silver coin was very rare, and a twenty franc note was unchangeable except at a heavy premium. To meet this difficulty the Belgian banks issued a quantity of notes for one, two, and five francs. The one franc notes were about the size of a visiting card, and made of such flimsy material that after passing through half a dozen hands they became indecipherable.

At the end of the first week the Kommandantur suddenly bethought itself of the ambulances, and one morning the entire staff was called on duty to receive the official visit of a Herr officer docter. He arrived at 10.30, an extraordinary looking person, very short and squat, his hair cropped closely, after the manner of the German officer, and his chin adorned with a straggly blond beard which stuck out straight in front of him. But he was a cheery soul, and so painfully polite in his quaint conception of the French language that we quite appreciated his visit. His first inquiry was about the patients. We explained that they had all been sent away. This seemed to puzzle him, and for quite ten minutes he stroked his beard and repeated many times to himself, "Ach! Then there are no wounded."

Later in the day we received another visit. This time it was a thin, ferrety creature, who explained that he had come to make an inventory of the stores. We handed him our carefully-kept Red Cross list, but this did not satisfy him. He insisted on weighing up and counting everything. Of course, he found everything in order, but he seemed convinced that we were hiding something, and started to poke about our personal belongings. One of the infirmieres, annoyed at having her boxes rummaged, arranged a beautiful "booby trap" for him. It consisted of a 2 kilo bag of zinc oxide placed in a tempting position on a high shelf. Mr. Ferret-eyes "spotted" it, and mounted on a chair to reach it down. But the bottom of the bag had been slit with a pair of scissors, and the inquisitive one received the contents in a shower. He was very angry in German, and retired swearing vengeance.

A few days after, some German wounded arrived, and were installed in the Palais de Justice, which had been taken over by the German medical staff. As there had been no engagement in the vicinity, we were rather puzzled to know how the casualties occurred. There was a rumour that a portion of von Kluck's army had had the misfortune to camp on a spot which had been mined by the retreating Belgians. Certainly we were awakened one night by a distant explosion, and it was on the following morning that these casualties arrived.

It is a popular belief that the Germans treated their wounded prisoners badly. But I, personally, have never heard of one authenticated instance. I do know, however, that they were shockingly brutal to their own men. A friend of mine was amongst the Belgians still retained at the Palais de Justice, and to him I am indebted for the following story which I believe to be perfectly true.

A Prussian soldier, who had been badly wounded, was placed in the mixed ward, which was under the care of Belgian infirmieres. He was very noisy and abusive, and amused himself all day by insulting his nurses. His conduct reached a climax when he struck one of the infirmieres whilst she was changing his dressings. The head infirmiere immediately complained to the visiting officer and asked him to remove the man to another ward. The officer refused to do so, but said that he would come and reprimand the offender. Walking to the bed where the man was sitting upright, he drew his revolver and struck him with the butt between the eyes, a blow which knocked him senseless. "There," said the officer, "that will keep him quiet for a bit."

Many of the private ambulances kept their doors open and their staff in readiness in the hope that some Belgian wounded would be sent into the town,

but when they learned that the German authorities would not permit their prisoners to be treated by their compatriots, they refused to continue. They only anticipated the closure of all private ambulances by a few days.

One day on reading the war bulletin we were surprised to learn that the Germans accused us of cutting the throats and gougeing out the eyes of the wounded whom they had entrusted to our care. In consequence, the German Governor ordered the wounded to be transported to the hospitals under the German care, all private ambulances to be closed within 24 hours and the Geneva Cross removed from the doors and windows. We obeyed. The charge was so preposterous that we were at a loss to understand the meaning of it.

But we were soon enlightened. Next day, when we had painted out our red crosses and were busy packing up the beds to return to their donors, two officials appeared and demanded our equipment and stores. They attempted to justify their action by quoting an extract from the Convention of Geneva which declares that all hospital stores must be at the disposition of the troops occupying the place. We pointed out that the beds, bedding, etc., were private property. But it was useless. They appropriated everything, and we learned afterwards that most of the spoil went to the Kommandantur for the accommodation of the officers and troops billeted there.

The English nurses, who had come over with the Red Cross contingent, were turned out and stranded in Brussels, and it was due to the efforts of the American Embassy that they were eventually repatriated. I believe it was only their fear of M. Max and the American Ambassador that prevented the Germans from submitting the town to the worst excesses. They have managed to get rid of M. Max, and if ever they come to blows with the Americans—God help Brussels.

Change of Address.

A. E. Boycott, F.R.S., M.D., B.A., 17, Loom Lane, Radlett.

M. F. Hopson, Junr., H.M.S. *Impregnable*, Plymouth.

G. S. Miller. F.R.C.S., M.B., B.S., 22nd General Hospital, British Expeditionary Force, c/o G.P.O.

Stanley Stevens, from 38, Craven Park Road, Harlesden, to "Shirley," Harrow Road, Wembley, Middlesex.

Surg. G. B. Cockrem, R.N., H.M.S. *Botha*, c/o G.P.O., London.

R. Gillbard, 188, High Road, Willesden, N.W.

Change of Surname.

A. S. Wohlmann, Esq., M.D., B.S., of Rotorua, New Zealand, has relinquished and abandoned the use of his said surname "Wohlmann," and does hereby give notice that he has adopted and intends henceforth upon all occasions and at all times to sign and use, and be called by his wife's family name of Herbert.

Letters from Men on Active Service.

Fort William,
Calcutta,
30th April, 1915,

MY DEAR ——

Ever so many thanks for the GAZETTES which you sent me. It was great to read all about the old place and all the men there, though it made me feel very home-sick. It seems ages since I last saw you, but such a lot has been crowded into the last six months that it has seemed a very big slice out of one's life. I wonder when I shall get back to Guy's again. I shall have to start as a ward-clerk, or even in the dissecting-room, to learn up all that I have forgotten, even if it was not a great deal! I have done what I can to keep up with my work, but opportunities have been few. On our big "trek" before mobilisation, I had some very heavy work with sore feet, as there was no M. O. and we had no orderlies. I found picric acid invaluable. I had also several cases of colic, due, I think, to cold. I treated them with Tinct. opii. m xv. with great success. Then, after mobilisation, I had a splendid morning with a needle and tubes of lymph and got through more vaccinations in ten minutes than I had all the time I attended Dr. Jane's séances! Out here, I learned at first hand all about jaundice as I was down with it two months myself. After that I went to our musketry camp, where I was acting adjutant, acting M.O., and assistant instructor of musketry all at once. It was very hot during the day and very cold at night, and we had an alarming number of cases of colic and diarrhœa. I used Ol. Ric. with a liberal hand, but one had to be careful, as there were some cases of dysentery amongst them. I had five in a fortnight. I also had an acute appendix and chorea (but successfully diagnosed!) whom I sent into hospital. I have also been to the eye-hospital here, which is in charge of Col. Maynard, I.M.S., an old Bart.'s man. I was very interested in his methods. The theatre is very large, with huge windows, which are all open. The anæsthetic used is $CHCl_3$ only, as ether is too volatile. It is administered by an unqualified student (native) through a Junker's inhaler; the anæsthetist took no notice of anything but the patient's breathing. Col. Maynard told me he has not seen a death yet in thousands of cases, and this he attributes to the plentiful supply of fresh air, which is the most marked difference between the theatres out here and at home.

So far, I have not met any Guy's men, but Blake (G.A.) is in Lucknow in the R.A.M.C., and so is Keith, who is in the 4th Queen's (R.W. Surrey). I have not seen him since I called on him at Suez, where we were hung up for a week on our way out here. He has been trying to get a transfer to the R.A.M.C., but, so far, without success. It certainly seems a great waste for him to be serving as a combatant officer. I hear they

have been recalling all medical students from the Front, and I was thinking of pushing in an application myself to be sent home, but I have just received marching orders, and leave in a fortnight for the Persian Gulf, in charge of some reinforcements to the 2nd Norfolks. You can imagine how jealous all the others are, who are not going! I have just been reading a letter from a man serving in the Gulf. He says that it is very hot, and that as much of the air as is not full of sand is occupied by flies! It sounds just ripping!

It is very hot here now, and I am feeling it a bit, as I have just come down from a hill-station, where I have been attending a musketry-course. Pachmarhi was the name of it, and I think it is the most beautiful spot I have ever seen. I cannot say the same for Calcutta, which I think is a horrible place. We should be much happier in a small station, even if there were fewer "attractions." And training is impossible; there is no ground, and, if there were, about half our men are swallowed up in guards and garrison duties of all sorts.

Well, I expect you have had enough of this, so I shall end here. Please remember me to all at Guy's.—Yours ever, H. HOGBEN.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

DEAR SIR,—The following conversation between a friend and myself may be of interest to readers of the GAZETTE:—

Member of Serbian Red Cross (to medical student whom he is trying to impress with his knowledge of medicine and surgery): "Oh, yes! I could teach you medical students quite a lot of things you don't know. Ever give salines? I saved a man's life with one."

Medical Student (bored): "Oh, really! How?"

Member of S.R.C.: "The doctor didn't tie him up properly after an operation and he oozed dreadfully. I gave him 1½ pints of saline and that bucked him up wonderfully."

Medical Student (offhandedly): "Did you give him surgical emphysema?"

Member of S.R.C. (learnedly): "Um! Ah!!! No! I didn't give him that. You see, *the apparatus at our disposal was very limited.*"

Exit Medical Student, feeling that he has scored.—Yours very truly, ST. GEO. B. D. GRAY.

7th June, 1915.

DEAR SIR,—I am sending a sample of our choice compositions here. They are not all in the Borough.—Yours faithfully, C. THOMSON.

"Sir

"I ham riting to ask yau if convenent to coll and see my Husbend as he is very porley been in voilen pain allnight I have had our Nurse and she sead he wants Meddesen as hes hed is so Bad sence this early morning and nurse has took hes tempesher and it is 1004 and she tought it was best to Leet you no your truly Mrs Mullin."

With the Red Cross in Serbia.

The outbreak of Typhus which occurred in Serbia in the winter was followed by a rapid spread of the disease through the country, infection being carried by the sick and wounded, and soldiers returning to their homes. That it was transmitted by lice was the usually accepted view.

In our town about 600 patients lay, and infectious cases among them were sent to the "Barak," or corrugated iron sheds where a Russian nurse had for three months before our arrival, alone and unaided, looked after its fifty inmates. No day at this time passed without several deaths; as soon as a hospital was opened a bullock wagon on which the dead were carried away "called for orders" as a matter of course. In one place, on the morning following the removal of a pile of dead, a supposed victim of the disease was found warming himself before a fire which he had kindled in a corner of the churchyard.

With skilled nursing, and in cleaner, better ventilated surroundings, the mortality was about 20 per cent. In its clinical features the disease seemed to differ in very few details from those described in other epidemics. Almost invariably fatal were the cases of early delirium, muscular tremor, or subsultus tendinum. One patient with incontinence had incessant hiccough for several days before his death. Diminished cardiac impulse and faint first sound marked the serious case, the pulse ranging from 100 to 120. Well marked rash with petechial hæmorrhages also suggested a fatal termination. Hypostatic congestion was usually present in severe cases, pneumonia occasionally setting in as a complication. Among sequelæ were suppuration of the submaxillary gland, erysipelas, and laryngitis. A case complicated by uræmia recovered.

In treating the severer cases the giving of brandy in increasing doses up to 6 or more ozs. a day combined with other stimulants seemed to meet with most success. The recuperative powers of some patients were extraordinary. Two evaded the night nurse and orderlies and did a 250 yards run in the snow one morning. By the bedside of another had been placed for two nights the lighted candle which the dying take in their hand, but on the third he astounded the ward by producing a cigarette from beneath his pillow and lighting it at the flame! T. A. T.

Syphilis of the Cardio-Vascular System.

(Continued from page 252.)

CLINICAL LECTURE BY HERBERT FRENCH, M.A., M.D., F.R.C.P.

The Treatment of Aortic Aneurysm.

Gentlemen,—Last week we were talking of syphilis of the cardio-vascular system in so far as it affects the arteries, and to-day we have to discuss syphilis as it affects the heart. As final remarks to append to what I said on the last occasion about aneurysms, I should like, before proceeding to discuss the heart, to say a word or two about the *treatment* of an aneurysm. The ideal thing, of course, would be to get the aneurysmal sac quite full of blood clot, and for that blood clot then to become organised into fibrous tissue. If that were brought about the aneurysm would be completely cured. I have once seen, in the *post-mortem* room, an aneurysm —the person in question was not known to have had one at all—which was absolutely full of fibrous tissue resulting from organised blood clot. Thus the cure of an aneurysm is, I suppose, possible. Here on the table we have a specimen showing the result of partial cure of an aneurysm by such organisation of blood clot within it.

Just think for a moment, however, what such a process of cure entails, and what hazards there are against its ever becoming complete. You have a rotten wall for your artery, and there is a tendency for it to bulge more and more. Clot may be laid down wherever there is stagnation of blood in the sac; but whenever the patient gets a coughing attack, or sneezes or laughs, or undergoes some additional strain, with the consequence that there is a little more bulging of the wall, the clot already there gets partly displaced. If you think of it, the chance of getting complete clotting up of the blood in the aneurysmal sac is rather remote in view of the vicissitudes to which the patient is subjected, and his various movements, as in coughing and laughing, even should he be confined rigidly to bed. The time required merely to get clotting must be considerable. It is not possible to constrict an artery in the chest as one can the femoral artery or the popliteal. To get clotting in a sac where, necessarily, the clotting must come about spontaneously may take months, at any rate, and, in my opinion, possibly years. And then you must remember that this clotting is not cure. It is only the beginning—the first step towards cure. The clot is soft material, easily washed out by the blood stream unless it becomes organised. Organisation cannot come about from anything in the blood itself. To organise the clot you must have growing into it from the tissues of the diseased artery wall itself new capillaries, which must sprout and branch and increase until they permeate the whole of the clot. These capillaries have then to secrete multitudes of small round cells—the fibroblasts—which in their turn could, under very favourable circumstances, convert the clot into a hard mass of fibrous tissue that cannot bulge any more.

What, however, do you suppose are the chances that, even when one has got an abundant and satisfactory clot in the aneurysmal sac, that the first little capillaries which begin to grow into it from the diseased aortic wall will remain unbroken? The patient sits up or lifts something, or coughs badly, and the first capillaries get torn through; and so on again and again. It must take, in my opinion, a long time under the most favourable circumstances, even after one has got the clot, before one can get the establishment of this capillary circulation through the clot. Moreover, think of the condition of the tissue from which these newly formed capillaries have got to grow. How many capillaries are in the inner wall of the artery? It is almost avascular. Does the syphilitic disease of the aortic wall furnish a better ground? No, but a worse. Therefore you will see that the chances of getting the cure of an aneurysm are exceedingly remote. The chances are very much against getting complete clotting to start with, and then organisation afterwards is very improbable because of the great likelihood that the new capillaries when they do begin to sprout will get torn away time after time.

Is it, therefore, worth while trying to get a cure of aneurysm? The only chance you have, I think, would be to keep the patient absolutely still for a very long time. He should lie flat in bed, and be treated upon such lines as will tend to make clotting more certain. People who have been starved have been found to be predisposed to thrombosis, and the same is true of people who have received very little fluid, and also of those who have lost blood. Therefore, the patient should be placed upon a low diet,

the fluids should be limited very much, and blood may be withdrawn at intervals by venesection. Such drugs may be used as have a tendency to induce clot. One of these is calcium chloride, 10 grains three times a day, or various other calcium salts might be used. Huge doses of iodide of potassium may also be given, partly because the primary disease is syphilitic, and partly because this drug favours coagulation and lowers blood pressure. One may also inject sterilised gelatine subcutaneously. This use of gelatine used to be dangerous because the material supplied sometimes contained the spores of tetanus bacilli, so that it is necessary to get the gelatine for these injections from special laboratories. A long time ago I once saw four people—all aneurysmal cases, and all treated with gelatine—who developed tetanus, all at the same time. The feeling then was that the use of gelatine should be abandoned, but nowadays one can get gelatine which has been sterilised so as to be certain of its containing no tetanus spores. Fifty c.cs. may be given under the abdominal wall, roughly speaking about once a week, and the treatment has been beneficial in certain cases.

When, however, you realise how many chances are against you, you will agree with me that only in very exceptional cases is it worth the patient's while to undergo the treatment at all. The best treatment for aneurysm is to make the best of it. Rather than lie up in bed for months on end in the remote hope of being cured, the patient will often be well-advised to adopt no special treatment at all, but merely to avoid such things as tend to make the aneurysm burst—such things, for example, as sudden physical exertion, or exposure to chills and consequent bronchitis and cough, or sudden bursts of temper. But as regards treatment for the aneurysm itself, I do not think it is worth the while of more than one person out of fifty to undergo it. The type of person in whom I might try to get a radical cure of the aneurysm is the otherwise robust young man, perhaps little over thirty years of age, who has probably a great many more years to live so that it is worth his while to devote three or four years of that life to getting cured. Unless he is prepared to go to bed for two years, and possibly for three or four, it is of little use attempting the cure, for it must take that length of time to get the complete filling up of the bulge with firm fibrous tissue. The treatment otherwise of aneurysm is to relieve the symptoms, and I need not go into the details of these. In very few cases is it advisable to put the patient to all the bother and trouble of attempting a radical cure.

II. Syphilis of the Heart.

Now let us pass to the effect of syphilis upon the heart. This part of our subject, like the other, resolves itself into two main sections or headings, namely, first aortic regurgitation, and secondly, neuro-myocardial changes.

(1.) Aortic Regurgitation.

This is due to syphilitic atheroma of the cusps of the aortic valves, identical with the atheromatous changes we have discussed in connection with the aorta itself. The softening of the valves causes them to sag, and presently to be incompetent. The condition occurs practically always in men, and with extraordinary constancy at about forty-five years of age. It is, indeed, astounding how often syphilitic aortic regurgitation comes on at forty-five. Syphilis never affects the mitral valve, nor the valves on the right side of the heart. The reason why the prognosis is so much worse than in the case of similar regurgitation due to rheumatic fever is easily explained. It is not the result of finite fibrotic changes in the valve due to the healing of endocarditis. Aortic regurgitation in a rheumatic case is due to definite and finite fibrosis, and, unless there are further rheumatic attacks, it will be no more in the year 1920 than it is now. It is finite in amount. In syphilitic cases, on the other hand, there is a slow progressive atheromatous change in the valve, so that in June there is more aortic regurgitation than there was in May. It is a progressive lesion, and every month there is more aortic regurgitation, until presently, no matter how much the heart hypertrophies, nearly all the blood pumped forward with each beat leaks back again before the next beat. The heart's task becomes as hopeless as an attempt to fill a sieve with water, and the patient is bound to die. There is nothing that will arrest the disease except possibly injections of "606."

As to symptoms, it is this lesion which produces the worst attacks of angina pectoris, with acute bouts of gripping pain in the precordium, radiating to the left shoulder and down the ulnar side of the left arm, often to the elbow, less often as low as the little and ring fingers. You will almost certainly meet with cases in which urgent treatment for relieving the symptoms of angina pectoris is called for. Amyl nitrite is the drug *par excellence* for such cases. Occasionally one sees another accident arising in these cases, and that is spontaneous

rupture of the diseased valve in a person who may, up to that moment, have been regarded as strong and well. The accident generally happens as the result of some extreme muscular effort, such as lifting a very heavy object; the patient collapses, and, although he may not die, he becomes a permanent cardiopath. So familiar, however, is aortic regurgitation due to syphilis, that after these few observations I leave this part of our subject and pass on to say a word or two about syphilis of the heart other than aortic regurgitation.

(2) NEURO-MYOCARDIAL SYPHILIS.

There are many ways in which syphilis may affect the heart muscle, but from an examination standpoint—and I suppose those to whom I am speaking are interested chiefly from that point of view—I think they may be classified under three headings: (1), the fibroid heart, which is the most important because it is the most common; (2), the burst heart, which is very rare, though one does see cases of sudden death as a result of this condition, and (3) heart block, a subject increasingly important nowadays in view of its investigation with the electro-cardiograph.

The fibroid heart clinically is a big heart, the left ventricle extending perhaps an inch outside the left nipple. The patient complains of shortness of breath, especially on exertion; he may have precordial pain; he is obviously a cardiopath, and yet on examining him you will generally detect no bruit. The condition is one of the many which come under the heading of *morbus cordis sine murmure*. Your business is to determine into which pigeon-hole of heart-failure cases the patient in question should go —whether the pigeon-hole (1) of valvular conditions, or (2) of muscular conditions, or (3) of high blood pressure, or (4) of heart failure secondary to emphysema or other lung conditions. You will exclude valvular lesions by the absence of definite bruit, or the presence at most of a soft systolic bruit at the impulse, and of history of rheumatic fever; you will exclude high blood pressure conditions by using the sphymomanometer; you will exclude emphysema, perhaps, by your general judgment; and thus you will arrive at the diagnosis of myocardial disease, possibly fibroid heart, simply by a process of exclusion. Even then you may be in doubt whether it is a case of fatty heart or of fibroid heart. The more definite the evidence of syphilis the more likely is it to be a fibroid heart, and the more fat the patient the more likely is fatty heart. If you have a person of between 40 and 50 who is not fat, who has other evidences of syphilis, and who has cardiac symptoms without high blood pressure or a definite bruit, you may presume that his heart failure is due to fibroid heart.

The lesion you see in the *post mortem* room is shown in this specimen. Here you see in the muscle pale patches scattered all through the myocardium, and you observe that there is great increase of size, especially of the ventricles. To what is the fibrosis due? Probably it is the result of multiple tiny collections of small round cells, corresponding to those of gross gummata, but on a much smaller and more diffuse scale, which in the course of time organise into fibrous tissue. The gumma needs to be a definite lump in order to be so called; these are more or less microscopic gummata, but their organisation will produce a fibroid heart.

It is not necessary in a syphilitic case that there should be a fibroid heart with diffuse fibrosis. What is sometimes found is a focal fibrosis—a heart perfectly normal except at one spot. Here I show you, for example, a specimen of a localised gumma of the heart. The patient happened to die whilst this was in the gumma stage; but if he had lived a few months longer this gumma would have organised and produced a local fibroid patch, such as I show you in this next specimen. Very often such a fibroid scar occurs near the apex of the left vertricle, and then, as this is the site of the biggest strain upon the ventricular wall, the scar bursts and results in sudden death from hæmopericardium. This is the commonest cause of spontaneous heart rupture. It is always in the same position—in front of the left ventricle, close to the apex. Here are two specimens illustrating this point.

(2) HEART BLOCK.

Now, if you have gumma of the ventricle, or a local fibroid patch of the heart near the apex, you cannot diagnose it from the symptoms. If, however, you get either the gumma itself or the fibrotic patch which results from the healing of the gumma in a syphilitic patient involving that very important neuro-muscular strand which acts as the means of transmitting the auricular impulses to the ventricles—the auriculo-ventricular bundle of His—you get definite symptoms due to what is known as heart block. The bundle of His is responsible for conveying impulses from the auricle to the ventricle so that the ventricular beats each follow after an auricular beat; and if the bundle is interfered

with, something or other is bound to go wrong in the transmission of impulses from auricles to ventricles. This interference is called heart block. It signifies that there is something blocking the transmission of impulses properly from auricles to ventricles along the auriculo-ventricular bundle of His, and although a growth might do it—sarcoma, carcinoma, or even rheumatic or other fibrotic changes besides those due to syphilis—syphilis is *par excellence* the cause of heart block cases. It is much the most common cause.

he had such a very slow pulse-rate, I took an electrocardiogram of the case, and I pass these copies of it round for you to see. (Fig. 1).

On these electrocardiograms the little curves which are marked "p" represent the auricular contractions, and the others the ventricular. The "p" curve is seen to have its notches at perfectly regular intervals, and the intervals between the ventricular curves are also absolutely even, but there is no sort of relation between the place where the auricular curves "p" come, and the place where the ventricular

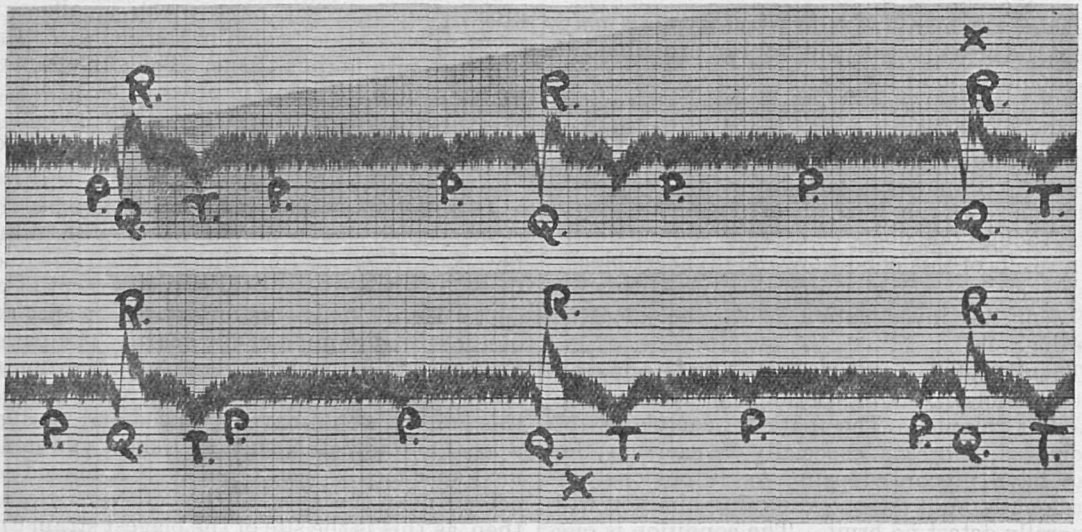

FIG. 1.—AN ELECTROCARDIOGRAM SHOWING COMPLETE HEART BLOCK.

Lead 1 is from right arm to left arm. Lead 2 is from right arm to left leg. The time marking is in $\frac{1}{5}$ and $\frac{1}{25}$ seconds. P. = Auricular wave. Q.R.T. = Ventricular wave.

The auricular waves are at the rate of 76 per second, and bear no relationship to the ventricular waves, which are at the rate of 31 per second. At the points marked with a X the P curves are not visible because they coincide with and are "swamped" by the ventricular curves Q.R.T., the auricle and ventricle beating simultaneously at these points.

What are the results clinically? Supposing you had complete heart-block so that it was quite impossible for impulses starting in the auricle to get through into the ventricle, what would you notice about the patient? There need be no heart failure at all. We had a patient in the out-patient department last week with complete heart-block and yet he looked perfectly well and was only very slightly short of breath on exertion. The reason he was sent to see us was because his pulse was exceedingly slow. He had bradycardia, his pulse-rate being 31 per minute, and sometimes you may find the pulse-rate down to even less than this. Because

curves come. That is to say, the auricles are beating at one rate and the ventricles at another rate—the former in this case at 76, and the latter at 31 per minute.

I take it that all of you know the principle of the electrocardiograph. When the heart beats it produces little electric currents, which we learn about in physiology. If the patient is perfectly still so as not to complicate the picture it is possible to lead off the little electric currents from that heart. The patient is seated in a chair, his left foot placed in an earthenware jar containing salt solution with a zinc pole outside it, and his hands are both

immersed in other similar pans in the same manner; it is then possible to obtain the result of the electrical reactions along several axes of the heart by leading the currents respectively (1) from the right arm and the left arm, or (2) from the right arm and the left leg, and (3) from the left arm and the left leg. One has an arc light which passes through a microscope, and near the eyepiece of the microscope there is graphically. The object of the microscope is simply to magnify the size of the fibre and its movements. The tiny heart currents transmitted to the terminals of the fine glass fibre give little shocks which deflect it momentarily; the auricle current causing a small deflection represented by the notch P and the more complex ventricular currents, causing larger deflections Q.R.T. such as those you see on the electrocardiogram I

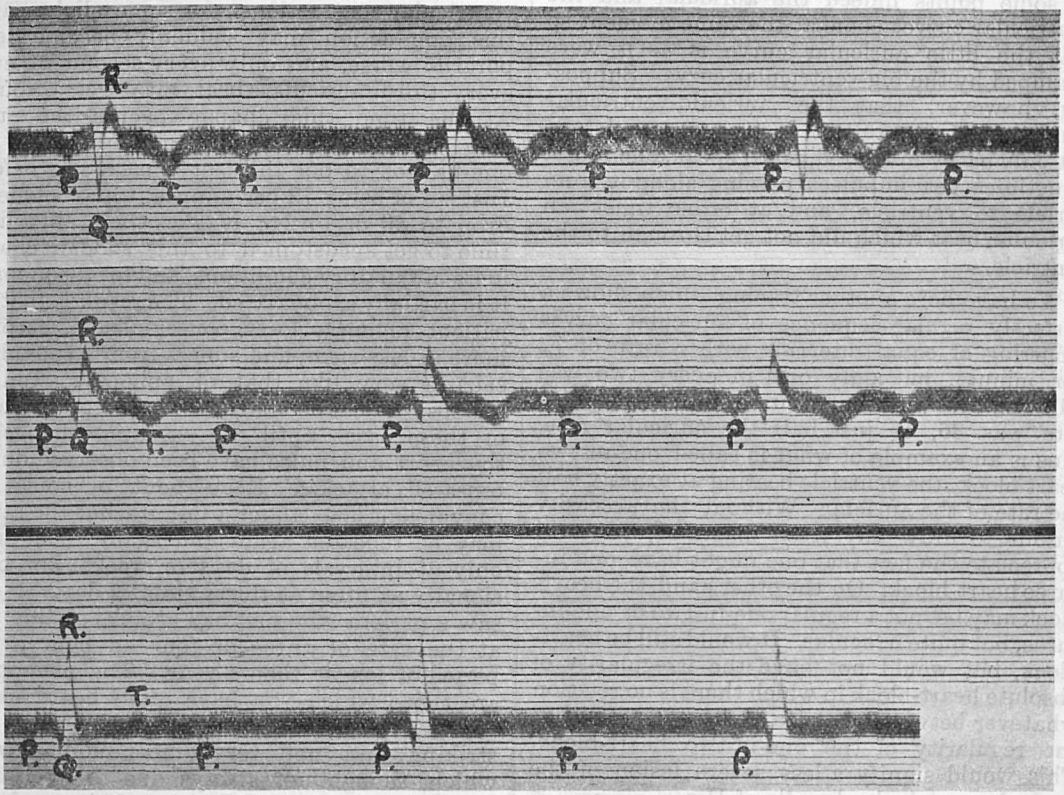

FIG. 2.—AN ELECTROCARDIOGRAM SHOWING ONE-IN-TWO HEART BLOCK.

Lead 1 is from right arm to left arm. Lead 2 is from right arm to left leg. Lead 3 is from left arm to left leg. The time marking (not shown in the figure) is the same as that of Fig. 1. P. = Auricular wave. Q.R.T. = Ventricular wave.

Every second auricular contraction is followed by a ventricular contraction. The auricular rate is 72 per minute; the ventricular rate is 36 per minute. The pulse was perfectly regular.

very fine glass fibre coated with silver, set vertically at a certain tension and kept from vibrating spontaneously by being surrounded by a strong magnetic field. Beyond the microscope is a screen, and behind this a photographic plate which moves at a fixed rate behind a slot in the screen so that any movement of the fibre is recorded photo-

have passed round. Although the machinery is complex, the procedure, so far as the patient is concerned, is perfectly simple; all he has to do is to sit quietly in his chair. An electrocardiogram has a great advantage over most other methods of heart examination, for it gives an exact representation of the time relationship of the movements of the auricles as well as those

of the ventricles. Were no electric currents produced by the heart, the register would show a perfectly straight line.

In the electrocardiographic record I have just shown you—the auricular curves coming at regular intervals, and the ventricular curve also at regular intervals, but with no relationship between the auricular curves and the ventricular —you have an example of complete heart-block. At some points indeed the auricular and the ventricular curves come at the same moment so that the little auricular curve is as it were swamped by the big ventricular curve. Supposing, however, that the auriculo-ventricular bundle of His were not destroyed completely, but only badly insulated, so to speak, one might sometimes get impulses passing along it from auricle to ventricle, and at other times an auricular beat which did not get through to the ventricle.

We have here another tracing which shows a perfectly regular sequence of auricular curves recurring at equal intervals with a rate of 72 per minute, but only one in every two was followed by a ventricular curve so that the pulse rate was 36, or just half the auricular rate. This is an example of what is called one-in-two heart block, the ventricle beating at exactly half the rate of the auricle. Without the necessity for me to draw any fresh diagrams, you will appreciate the fact that one might have one-in-three heart-block. On the other hand, the heart-block may be, not a regular one-in-two or one-in-three, but quite irregular. It would still be heart-block, but would not have the irregularity of absolute heart-block in which there is no relation whatever between the rate of the two beats, nor the regularity of the one-in-two heart-block. This would signify a less severe lesion of the auriculo-ventricular bundle of His.

In such a case one might get three or four auricular and ventricular beats in perfect sequence, and then would come a missed ventricular beat, and the pulse would show corresponding irregularity in rhythm. Sometimes the electrocardiodram shows only a delay between the auricular curve P and the ventricular curve R without any actual failure of the R curve to occur; it is essentially by means of electrocardiograms that these various types and degrees of heart block can be detected and understood.

What are the symptoms that are apt to arise from varying degrees of heart block? There are no symptoms at all so long as the heart remains regular. If one beat in two gets through from auricle to ventricle regularly, and this rhythm remains permanent, there may be complete absence of symptoms; it is when the number of impulses that get through from auricle to ventricle varies from time to time that the most prominent symptoms appear. Suppose, for instance, that the power of conduction from auricle to ventricle is just "touch-and-go," so that on ordinary occasions most of the auricular contractions are followed by ventricular contractions; for some slight cause this conduction may suddenly become temporarily worse, and only every second or even every third auricular beat may get through. At the time this change occurs the pulse rate at the wrist will suddenly drop to one-half or to one-third of what it was before. Instead of being 72 per minute it may suddenly drop to 36 or to 24; it takes the brain a little time to get accustomed to this sudden change in its circulatory conditions, and for the moment it is partially asphyxiated. The result is that the patient suddenly loses consciousness, becomes more or less rigid, and suffers from a convulsive seizure very like that of epilepsy. Indeed, epilepsy has been diagnosed in error in many of these cases until the essential changes in the heart and pulse have been observed during repeated attacks. Each bout of coma and convulsions lasts about a minute, but the attack may be repeated again and again; sometimes only at intervals of days or weeks, but occasionally as often as thirty times a day. I once saw a patient who had had attacks of this kind at the rate of three or four an hour over a period of longer than a year. The phenomena are those which you have often heard spoken of as "Stokes-Adams Syndrome"—a very striking and not very uncommon affection which, though not always due to syphilis, is always the result of disease of the auricular-ventricular bundle of His—"heart block"—and the commonest cause of this is syphilis of the heart.

EPITOME OF A CLINICAL LECTURE UPON SYPHILIS OF THE CARDIO-VASCULAR SYSTEM.

The introductory case was one of intra-pericardial rupture of a minute aortic aneurysm causing sudden death in an apparently healthy person.

EFFECTS OF SYPHILIS UPON THE ARTERIES.

These are, mainly, two, viz.:—

1. *Endarteritis obliterans*, causing softening with or without previous thrombosis, and affecting mainly—

a. The middle cerebral artery with consequent hemiplegia, and

b. A spinal artery causing so-called transverse myelitis and paraplegia.

These results occur mainly between 20 and 35 years of age.

2. *Atheroma of the aorta,* especially at the origin of the valves, and in the first few inches of the aorta above the valves, causing—

a. Aortic regurgitation, and all its secondary effects.

b. Angina pectoris.

c. Bulging of the aortic wall=aneurysm.

Aortic aneurysm clinically sub-divided best by position of the aneurysm, viz. :—

a. Between aortic valve and innominate artery: if very small may be entirely inside pericardium; chief cause of fatal hæmopericardium. If larger, a bulging tumour in the first and second right spaces pulsatile, perhaps, to ear only with impaired note; may obstruct superior vena cava or right upper bronchus, but seldom causes other pressure signs. N.B.—Bruit over any aneurysm exceptional rather than the rule.

b. Involving the aorta in first part of transverse arch, including origin of innominate ; similar bulging pulsatile tumour to right of sternum with impaired note. Pressure upon lower part of right brachial plexus with pain in right chest, shoulder, and arm. Right pulse smaller than left, possible obstruction to superior vena cava and right bronchus, but no unequal pupils, obstruction to œsophagus or voice changes; may cause tracheal tugging.

c. In distal half of arch involving origin of left subclavian. Unless huge no pulsatile tumour, but a maximum of pressure signs including interference with left upper bronchus, paralysis of left recurrent laryngeal nerve and brassy cough; left pulse smaller than right; cervical sympathetic irritation or paralysis with unequal pupils; possibly stenosis of œsophagus; erosion of upper dorsal vertebræ and pain in back.

d. Involving descending thoracic aorta. No pulsatile tumour signs; very few pressure signs; the latter being in main interference with left lower bronchus with consequent abnormal physical signs in left lung; perhaps stenosis of œsophagus; and pain in left side of chest from erosion of mid or lower dorsal vertebræ and irritation of intercostal nerves.

e. Involving abdominal aorta, generally at cœliac axis. Main symptom epigastric pain; paraplegia very rare. Diagnosis very easy if pulsatile tumour; very difficult if none felt.

Discussion of *mode of cure of aneurysm:* conclusion that in most cases not worth attempting. Also sites of rupture shown in specimens :—

1. Into pericardium.
2. Into pleura or lung.
3. Into trachea or bronchus.
4. Into œsophagus.
5. Into superior vena cava.
6. Into pulmonary artery.
7. Externally (exceedingly rare).

SYPHILIS OF THE HEART.

1. *Aortic regurgitation* discussed above; age generally between 40 and 50.
2. *Angina pectoris,* ditto.
3. *General fibrosis of heart,* or fibroid heart.
4. *Focal fibrosis of heart;* possible spontaneous rupture with or without previous aneurysm-formation. Rupture always near apex of left ventricle; death from acute hæmopericardium.
5. *Gumma of the heart;* seldom distinguishable from the effects of healing of gumma, namely, local fibrosis ; specimens shown. If involving bundle of His, partial or complete heart block. Stokes-Adams syndrome.

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J. H. Donnell, M.B., B.C., Camb. : Coma in a child.—*Ibid.*

W. Lyne Blight, M.D. Durh., F.R.C.S. Eng. : Abstract of an address on arterio-sclerosis, delivered before the Cardiff Medical Society.—*Lancet,* June 5th, 1915.

Sir James Goodhart, Bart., M.D., LL.D., F.R.C.P. : The pulsus alternans.—*Ibid.*

Charles Higgens, F.R.C.S. : Treatment of post-influenzal cough, by British-made Lysol.—*Ibid.*

W. Sampson Handley, M.S., F.R.C.S. : A clinical lecture on a case of anthrax.—*Clinical Journal,* June 2nd, 1915.

E. G. Graham-Little, M.D., F.R.C.P. : (1) A persistent ulcer of the plantar surface of the right foot resulting from exposures to X-rays ; (2) Folliculitis decalvans et atrophicans ; (3) Multiple rodent ulcers of the left cheek of unusually short duration.—*Proc. Roy. Soc. Med.,* Dermatological Section, May, 1915.

Arthur F. Hertz, M.D., F.R.C.P. : Some alimentary canal cases of radiological interest.—*Ibid.,* Electro-Therapeutical Section.

Alfred C. Jordan, M.D., F.R.C.P. : Glycosuria in chronic intestinal stasis.—*Ibid.*

T. D. Lister, M.D., B.S., M.R.C.P., F.R.C.S. : Discussion on the treatment of phthisis by the induction of pneumothorax. Opened by Thos. D. Lister, M.D., etc.—*Ibid.,* Therapeutical and Pharm. Section.

Pass List.

University of Durham.

At the Convocation held on Saturday, March 27th, 1915, the following degree was conferred :—

DOCTOR OF MEDICINE (M.D.)

R. Cyril H. Francis, M.B., B.S. Durh., L.R.C.P. Lond., M.R.C.S. Eng.

Anthony C. Clifford.

A Personal Reminiscence.

AN eight years' acquaintance, gradually ripening into an intimate and endearing friendship, gives one endless opportunities of knowing one's friend through and through. A friend is, as a rule, more unbiassed than a relative and more sympathetic than a colleague; but in his case I feel certain that relative, colleague, and friend will all agree, and I can only hope to give voice and expression to the sentiments that all who knew him must be feeling at this time. "A noble death suits his sweet and blameless life," writes his brother. "We are quite upset about him," said one of his colleagues at Guy's to me the other day. "It is a great grief to all here," writes his superior officer at Canterbury, where he was stationed before he left for the front.

A mutual friend, a clergyman, writes, "We were very distressed to hear the news. . . I had a great regard for him." Another, an officer, writes, "It is indeed very sad news about Clifford, I did not even know that he was at the Front." In my own case a thousand and one things remind me of his personality. Letters, papers, music, pictures, places, incidents, and endless associations continually stab me through with the reminder that he "is not." I can think of nothing that can ever by any possibility compensate for his loss. I wish no one to take his place. My hope is that at some distant point in eternity, if God can grant it, he will again fill the blank now left in my life. Meanwhile, to honour his memory and to inspire all those who admired and loved him with a similar hope is my one consolation. Hence these lines.

His character was so many-sided and so deep, yet at the root so simple and disingenuous, his manner and his ways so courteously reserved and yet at times so open and affectionate, his intellectuality so subtle and yet so straightforward and practical in its result on his actions, that it would be possible to write a whole volume on his life. I have had intimate friends of all ranks and ages and tastes, but I have never known one who appealed to me from every side so much. I am certain that this is the impression that he made wherever he went and whatever he did.

Handsome and comely in appearance and of an impressive and almost commanding personality, conscious of its powers, yet with a certain tentative and gentle manner which at once disarmed jealous criticism, one always felt that there was something there deep down in his nature that would come out from him when occasion arose. It was partly intellectual and partly emotional. To me it was like the ocean with its unfathomable secrets and its boundless reserve.

A really great personality combines greatness with simplicity, genius with humility, reserve with unaffected charm. It was the combination of these qualities that made him so fascinating and so attractive.

When a relative or a friend has gone from us into the Great Unknown, never to return, we naturally try to remember everything that may serve to bring him back to our minds, not only because his memory is dear, but that we may perpetuate his existence by copying his virtues in our own lives. We feel that this is the only thing left to us. May I, therefore, enumerate the many aspects of his character and suggest those traits which when added together made up that complex and well-balanced character which always seemed to me to distinguish him from most men?

First, his *conscientious attention to duty, whatever it was.* My knowledge of this sterling quality dates back to the old Cambridge days. It was always "lectures" in the morning, "labs." in the afternoon, and "reading" at night. At the same time he always found time for reasonable pleasures, but never so as to clash with necessary duty. In this relation witness his obtaining a medal for riding at the O.T.C. whilst an undergraduate. I well remember, too, his coming to see me almost daily during an illness at Cambridge immediately before and during the time of his Second M.B. examination, which, as all medical men know, is very stiff indeed, and is passed as often as not after a man has gone down from Cambridge. And this was the same when he first went to Guy's. It was "work first and pleasure afterwards." The result was a steady rise until he eventually became a house-physician and had meanwhile qualified for all his diplomas and degrees (no less than five in all).

And it was this conscientious attention to duty which decided him to fight for his country and give up his career. Some of his friends rather criticised this decision, but I beg leave to observe that an intensely religious priest said to me only the other day, "Of course, the finest thing a man can do just now is to fight for his country." By temperament a man of peace, his sense of duty and sense of proportion enabled him to overcome all excuses, and he did "the finest thing." Truly it might—it ought—to be said of him "*dulce et decorum est pro patria mori.*"

His *excellent judgment of men and things.* This used constantly to surprise me in one so young. His breadth of view was extraordinary, and yet he was essentially a man of principle. Looseness of morals, slackness of ideals and general weakness of character would have shrivelled up into shame-faced corners at a glance from him. Yet he always knew how to take a man in his setting and to make allowances for the limitations and weaknesses of poor frail human nature. I remember well his gently rebuking me for my intolerance of a mutual acquaintance. He said, "You must make allowances for people like that and not expect them to be very different." It was a lesson that I never forgot. I take it that a medical man

2nd Lieut. A. C. CLIFFORD

Killed in action whilst serving with the 3rd Dragoon Guards at Ypres. on June 1st, 1915.

Educated at Marlborough; Emmanuel College, Cambridge; and Guy's Hospital. B.A., M.B., B.C. (Cantab); M.R.C.S., L.R.C.P. President of the Residents and House Physician, Guy's Hospital.

has to deal with every type of humanity and that a broad outlook is necessary. If this is the case (and a very wide experience of medical friends has convinced me that it is so), a medical student who, from the beginning of his career, is able to strike the balance between what people might be and what they actually are stands a good chance of leaving the world better than he finds it. One always felt that Clifford had an influence for good with everyone that he met. This was part of the secret of it.

His *courtesy to all.* Some men are courteous and weak. Clifford was courteous and strong. His attitude as a man of action (and for all his subtle intellectual qualities and gifts he was essentially a man of action) was always the attitude of a gentleman. His manner was so gentle and kindly that until I knew him well I was surprised at his strength of will and at the very firm stand he could take. It was the *suaviter in modo* and the *fortiter in re* wonderfully balanced. Some men get their way (or rather try to get their way) by a brusque and almost brutal manner. All who knew my friend must have been struck with the extraordinary balance of gentleness and strength in his nature. It was one of the rare gems —perhaps the rarest gem—of his personality. I have seen his eyes beam with affection; I have seen them flash like fire.

His *simplicity of life.* Coming from a most cultured family, accustomed to the very best society, and, doubtless, whenever he had time to move in it, adorning it with grace, I was constantly impressed with his simple (often almost ascetic) mode of living. When he first became assistant house-surgeon and had a room of his own at Guy's, I remember calling to see him one day early in the afternoon. He had been too busy to "bother" about lunch, and was eating chocolates and drinking lemonade whilst waiting for a "call" to his ward! Yet he could enjoy a "fashionable" meal as much as any man. We have been together to the most intellectual plays and concerts in town, and we have also been to picture palaces and found them interesting—even in poor parts of London. If the films were not interesting the people were! We have been in taxis and we have had many a 'bus ride, and have enjoyed both. All this shows a conception of life which determines to make the best of things and to see interest and even beauty in the common things of life. It was the same in his intercourse with others. He was as courteous and as considerate to his landlady or to a chance poor acquaintance as to his equals in social rank. In other words he was human, and he was a gentleman. He realised that other people have their lives to lead, that others have their grooves in which they moved happily. This is the great and yet simple view of life. It makes for sincerity.

His *general culture.* In spite of the simplicity which enabled him to take people and things as he found them and to see the best and to make the best of them, he was, nevertheless, highly cultured. Culture, in the Greek sense, seemed to colour not only his thoughts, but to influence his every movement and expression. It was partly the result of that wonderful sense of proportion that was born with him and partly the result of a refined home and a subsequently refined education at Marlborough and Cambridge. If there is one thing that Oxford or Cambridge can do for a man it is to make him cultured. That is, if he has the temperament for it, not otherwise. And Clifford was essentially a man of culture. Culture seemed to emanate from him. Vulgarity of any kind in his presence would have been unthinkable.

The logical result of this was that he never made the mistake that so many professional men make—he never allowed himself to remain in a groove. Devoted to his most noble profession and at all times willing to sacrifice himself for it, he had, nevertheless, interests of all kinds outside his work. Poetry, music, art, the drama, architecture, everything that was interesting and beautiful appealed to him. A man's work surely gains by his having interests outside. It gains in freshness, in point of view. It tends to make his mind elastic and more ready for an emergency. It prevents his becoming a mere machine and makes for originality in his own special line. It is said that every man should have a hobby. Everything that was not his own particular work was Clifford's hobby. The result was a width of vision and a mind stored with treasures of which all who conversed with him would reap the benefit. It might be truly said of him that whatsoever things were pure, whatsoever things were lovely, whatsoever things were of good report, these things he thought upon.

His *thoughtfulness.* This was partly the result of his mental temperament, partly owing to the culture of his mind, which enabled him to look at a subject from so many points of view. Many and many a time I have been impressed by some remark gently edged in, as it were, which would solve a difficulty that I had, perhaps, been thinking over for years. His "humanly philosophical" view of life and the many points of view from which he would always regard any subject or person enabled him to get at the root of many a problem by a sort of instinct. He had the mind of a statesman. I have known few (if any) who could place men so well in their relation to others or to their surroundings. It was a very great gift, and it was always tempered with charity. Sarcasm was foreign to so sweet a nature, and would only be exercised as a last resort. It was then terribly effective.

His *humility.* What was so surprising to me was that although conscious of many of his powers and gifts and always able and willing to use them at a moment's notice, if needs be, he never obtruded them. One has known many men, greatly gifted, who would

make themselves absolutely obnoxious by parading their powers on every possible occasion, in season and out of season. Clifford was the reverse of this. If necessity arose he would say his say without fear or favour. Otherwise he would retire modestly into his shell, whilst others were vaunting themselves fatuously and as likely as not talking drivel. It required circumstances or encouragement to draw him out; but once drawn out of his retirement he was as strong as a lion, and though his manner would be gentle, it would be the gentleness that concealed a great strength, which would wither feebleness and falsehood with an unconscious scorn.

Another aspect of his natural modesty was the fact, self-evident to anyone who knew him intimately, that he had no ambition, as the word is understood generally. Whilst he expected to pass his examinations and hoped for promotion, his real motive was to do his work thoroughly well, promotion or no promotion. With many men their work is the lever with which they hope to force their promotion and to obtain kudos for themselves. With him promotion meant simply a wider sphere of usefulness and interests. His brilliant career was an exemplification of the fact that "The meek shall inherit the earth." As an illustration of his attitude in such matters I remember that a few weeks before the war commenced he told me that he had been elected President of the Residents at Guy's. I was, of course, delighted, but twice during our conversation about it he told me that "he never expected it," yet I could see that he was very gratified with the honour. His transparent and perfectly sincere humility was one of his great personal charms.

Finally, his *religion*. I say religion, because if I were to say that he was religious I should express nothing. So many people are religious, and are not much the better for it; but Clifford was much more than this. He was a Churchman, but he was not merely a Churchman outwardly. With him the Christian religion had a certain relation to everything that he did and thought. It was, consciously or unconsciously, the mainspring of his actions and the motive of his life. He seldom talked about it, but he acted up to it and lived it.

And it is this which makes one feel that if so brilliant and useful a career has been cut short by a noble death of self-sacrifice for his country, we may be quite certain that, to quote the words of a friend, "he has been called to some higher service."

Let all of us who knew and loved him—and there must be many—strive to copy his manly and noble qualities and let that be our motive which was the undercurrent of his life. We may then hope to meet him some day where the wicked cease from troubling and the weary are at rest. Requiescat in pace!

June 11th, 1915. C. W. P.

Nursing News.

Matron's Office,
16th June, 1915.

Miss Evelyn Densham, Assistant Matron, Guy's Hospital, 1912, has been appointed Matron of the Duchess of Westminster's Hospital, Le Touquet, where 270 beds are always full, and the hospital is doing very good work.

On June 9th Miss Lear, late Sister Esther, and Miss Ripley, late Sister Lazarus (who had completed their six months' engagement with the French Flag Corps), returned to France as C.H.R. under the War Office, as also did Miss Todd.

Miss Broome, Guy's Institution, who had worked in France for six months under the British Red Cross, has now joined the War Office C.H. Reserve, and was in the same party.

Travelling in the same train were two large contingents of nurses from Australia and Canada, eventually destined to join their own troops. It was interesting to learn in conversation with the Australian nurses that an educational test was necessary before being accepted by a hospital for training. The course was for four years, and there was a strict system of State registration.

Miss Gibson, Guy's Institution, has returned from five months' work at Arc-en-Barrois to take the post of District Coach for July and August.

Miss Southcott, writing 4th June, from Boulogne:—"I am still here, as are Sisters Campbell, Phillips, Douglas, Witchell, Twose, and Barker. Miss A. Daniels, who has been here since November (except for two weeks when she relieved at a Clearing Hospital), left a fortnight ago at two hours' notice to go to Le Treport.

"The Club here for Military Nursing Sisters is much appreciated. Mrs. Robertson Eustace is charming, and most kind to us all. She told us she had received a subscription from the Guy's Nurses' League."

Miss Roach says:—"I am on night duty, and for the first time have a little breathing space. I have 72 beds distributed over four straggly passages, called "overflow," and until two nights ago there were even other patients on the floor between the beds.

"I hear a second Sister is to be appointed, and I shall be thankful to be able to do a little nursing as well as the absolute necessities. It is appalling to see the men maimed and tortured in such a ghastly fashion. To me the "gassed" men are the most tragic feature of the war; their sufferings are beyond description.

"Misses Wilson and Colston are at No. 13, and also Sister Kiddell at No. 13 Stationary."

Miss Twose writes, 10/6/15 :—"I am still at No. 11. Just now, while we are not very busy (only about 100 wounded in last week), the whole hospital is being cleaned and fumigated. We are very glad, as there has been so much gas gangrene and previously so little time to carbolise in between the cases, we felt the germs must be everywhere.

"I enclose a snapshot (passed by Censor) of our show ward. It is on the ground floor, the salon of the hotel. The large mirrors and candelabras do not quite give the idea of active service.

"We have had a number of the gas poisoning cases and some excellent results in spite of a number of deaths. Here atropine has been used, 1/100 gr. four hourly, and strychnine, 1/60 gr. four hourly, strong coffee and as much sugar as the patient can possibly take."

Miss Lüders, late Sister, Government Hospital, Kandy, Ceylon, writes :—

Lady Paget's Hospital,
Serbia,
27th May, 1915.

"I have now been working five weeks in nursing typhus, mostly Austrian prisoners and Serbian soldiers. When I arrived here with four other nurses we found that three nurses only had attended between 500 and 600 patients, so you will undertansd that more help was urgently needed. Twenty more nurses arrived from England, and we are now properly organised and each individual patient gets the necessary attention.

"We have Austrian prisoners for the cleaning of the wards, and the more responsible of them help with the sponging of the less severe cases, and superintend the bathing of the convalescent patients, and are, on the whole, a great help to us.

"It is a great pleasure to see the patients respond to the treatment. The death rate of the past month has gone down considerably. I am glad to say the typhus epidemic is subsiding; we only get a few fresh cases each day—it used to be 40 or 60, and I have known over 100 per day. We all wear special garments in the wards which cover us from head to feet and so protect us from the vermin."

Miss Finnis writes from —— Barge, Ambulance Flotilla, British Expeditionary Force, 28th May, 1915.

"Since my last letter I have been in many places. The Matron of No. 1 General Hospital left on April 23rd with eight of us to start a new 1,000 bed hospital No. 18. It was all under canvas in a delightful spot. We each had a bell tent, and I made mine quite pretty with the aid of cretonne and packing cases. We had a very busy time in getting the hospital ready. The tents were up when we arrived. Two days later, when we had just got all the beds made up, our first convoy of 400 cases came in, followed in a few hours by 500, and as there were only 15 sisters, we had our hands full. The rest of the staff, 25, were expected daily.

"Two days later Matron had an urgent wire asking for the loan of 10 Sisters for a dressing station, so off they went, leaving five, one being Matron, and one on night duty. We just worked hard all the time, with only a few minutes off for meals; it was only a case of being able to do dressings and feed the men. This went on for two days, as the expected Sisters could not get through owing to the trains being full of troops.

"We had been there three weeks, when late one night Matron came to my tent to say orders had come to start early next morning to take charge of a barge, so I had to be up at cockcrow to pack my bed and baggage.

"Once settled on the barge, we start at once for ——, quite close to the firing line. We take only serious cases who could not stand the jolting of the ambulance trains, and so get them straight from the field ambulance stations. They are all more or less in a dying condition, and I now understand why the majority of cases at the base hospitals are walking or sitting, for these poor men never reach there.

"We can take 34—one ward well fitted with beds, and every comfort; one medical officer, two sisters, and some orderlies. We go between —— and ——, and it takes 12 hours to do the journey, and as we cannot travel at night, as a rule, we are 24 hours with the patients and 24 hours on the return journey, when we rest and make up the stock. The first trip down we had a ghastly time—nine deaths in the 24 hours, and we only just landed some of the others alive.

"The canals run all over this part of the country, and as the army advances so shall we. One night there was a terrific bombardment going on, shells were flying right over our heads, one burst only 500 yards away and killed some workmen. The next night all the place was being evacuated. Again, next day there was a huge artillery duel going on, shells flying all over the place, so we really feel we have been under fire."

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Syphilology and Venereal Disease. By C. F. Marshall, M.D., F.R.C.S. (Baillière, Tindal & Cox, 1914). Price 10s 6d. nett.

This is the third edition of Dr. C. F. Marshall's book, and in order to bring it up to date the work has been largely rewritten. The object of the author has been to give a complete account of the venereal diseases, and it may be said at once that he has been very successful. As might be expected, by far the greater part of the book

is devoted to the consideration of syphilis, beginning with a brief resumé of the very vexed question of its antiquity, and ending with a full account of hereditary and congenital syphilis.

The chapters on the pathology of the disease and its serodiagnosis contain a summary of the most important recent work, including Noguchi's successful culture experiments with the spirochæte, and the views of Maclennan, Kvzyztalowicz and Siedbecki, Ross, and MacDonagh on the life-history of the organism. Both Ross and MacDonagh hold that the spirochætes are only male gametes. and on their view the life-history would correspond to that of certain parasitic sperozoa. This may or may not eventually prove to be true, but, attractive as this theory undoubtedly is, we are not of the opinion that sufficient proof has as yet been brought forward, and for our own part we consider that Noguchi's work would tend to negative the idea.

After giving a good account of the primary lesion, the author proceeds to describe how syphilis may affect the various "systems," beginning with the cutaneous manifestations. In the chapter on the alimentary system the question of gastric syphilis is discussed. There can, we suppose, be little doubt that syphilis may in rare cases be a cause of what would clinically be considered a case of gastric ulcer, but in this connection we may refer to Dr. Bolton's book on "Ulcer of the Stomach." He points out that ulcerating gummata in the stomach are undoubtedly found, but that there is not very conclusive evidence that syphilis plays a direct part in the production of simple ulcer. He quotes a case of his own in which the latter condition was probably produced by infection of the gastric mucosa by organisms derived from secondarily infected syphilitic ulcers on the legs, so that syphilis was only indirectly responsible.

In the chapter on the nervous system the important discovery by Noguchi of spirochætes in the brains of cases of general paralysis, and its confirmation by Mott and others is recounted. In considering syphilis of the genito-urinary system Dr. Marshall discusses "the syphilitic factor in Bright's disease." That acute nephritis may occur during the course of secondary syphilis, and be directly due to specific infection has we consider been proved beyond question, chiefly owing to the observations of the French school, and we remember reading an extremely full account of such a case in some Clinical Lectures by Professor Gilbert, But whether syphilis is frequently an important agent in the causation of chronic nephritis is another matter. The opinion of Dr. Leonard Guthrie that "chronic interstitial nephritis in young children is due to hereditary syphilis" is quoted, but we must confess that, although admitting that some of such cases are certainly of syphilitic origin, we are inclined to attribute most of them to chronic bacterial infections, the bacillus coli probably being sometimes the causal organism.

A very full account of the different methods of treating syphilis is given, and stress is laid on the fact that, in spite of the new arsenical compounds, mercury is still the most important antisyphilitic drug we have. When salvarsan was first introduced it may be remembered that Dr. Marshall, in England, and Prof. Gaucher, in Paris, were inclined to condemn its use. The former at any rate, however, now admits its great value when used in conjunction with mercury.

The chapters on hereditary and congenital syphilis we would particularly recommend. Several interesting points are raised, one being syphilis of the third generation, on which there has been so much discussion. Since the Wassermann reaction came to our aid it is becoming clear that many obscure diseases are associated with congenital syphilis: as an example, we may quote paroxysmal hæmoglobinuria, of which two cases have recently been in the wards, both of whom were congenital syphilitics. Diabetes insipidus, too, is another rare disease which may occur with the congenital or acquired forms of the disease. Dr. Edmond Fournier, in his "Syphilis Héréditaire de l'Age Adulte," insists that symptoms of congenital syphilis of the most diverse kind appear at any age, and he brings forward numerous cases in support of his contention. It is probable that the possibility of a congenital taint is too often forgotten when we are dealing with doubtful or obscure cases.

Altogether we consider that Dr. Marshall has succeeded in his attempt to give as complete a review as possible of syphilis and its results, as we know them to-day, and the value of the book is considerably enhanced by the references to original articles given at the end of each chapter. In the latter part of the work chancroid and gonorrhœa are considered—briefly, but fairly completely. In connection with the first-named disease the whole credit of discovering the causal organism is given to Ducrey, whereas to Cluna belongs the credit of demonstrating it in the tissues, and of describing the chain-form of the bacillus.

The work concludes with a short chapter on syphilis and the public health, which contains a discussion on the important subject of how long a syphilitic should wait before marrying. We are glad to find that the author condemns the fixation of an arbitrary time-limit, and insists that the individual case must always be considered.

Births.

CLARKE.—On May 26th, at Prince's Gate, the wife of Lieut. K. B. Clarke, R.A.M.C., of a daughter.

DOHERTY.—On May 15th, at Stranraer, Bernard Gardens, Wimbledon, to Mr. and Mrs. J. W. Doherty (*née* Helen Verran), a daughter, Margaret Constance.

MALLESON.—On June 12th, 1915, at 30, Thurlow Road, Hampstead, to Mr. and Mrs. H. C. Malleson, a son.

Marriage.

PURDOM—MELHUISH.—On the 11th June, H. Neish Purdom, L.D.S., R.C.S. Eng., son of Dr. T. E. Purdom, of Croydon, to Dona Mary, 2nd daughter of Mrs. Melhuish, of Walton Park, Clevedon, Somerset.

Death.

MASON.—Alfred Leighton Mason, L.D.S. Eng., of Warham Cottage, Lowestoft Road, Gorleston, and 36, Regent Street, Great Yarmouth, aged 34 years.

W. E. T.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE papers do not bring us much glad news nowadays, but on Wednesday last week they contained the list of names of men and women mentioned in Sir John French's dispatches, and on the following day the recognition and awards for that fearless bravery and undying devotion which is being shown "somewhere in France" every hour of the day. How eagerly we scanned those columns in search of names which have figured at Guy's, and how quickly we found them. A full list of all these names appears farther on, so let it suffice here to pick out those names which have been associated with Guy's most recently. They are two—Lieutenant Philip Smith and Sister Kiddle.

Lieutenant Smith received his early education at Sherbourne School, and entered Guy's in October, 1904, and qualified M.R.C.S., L.R.C.P., in January, 1912, after having been Dresser to to Mr. Dunn and Mr. Steward, and Clinical Assistant to Dr. Hale White and Dr. Pitt. He was then appointed H. P. to Dr. Shaw, and was Senior Charity from November, 1912, to April, 1913. He joined the Royal Fusiliers in September last, and it was while attached to that regiment that he gained the Military Cross for conspicuous bravery.

Sister Kiddle, who was also mentioned in despatches in February last, has now been awarded the Decoration of the Royal Red Cross.

We congratulate all who have received such high recognition from the Nation, and on behalf of the Hospital we thank them for so worthily upholding the traditions of Guy's.

We regret to have to publish that two Guy's men have fallen since we last wrote, Lieutenant F. Augustus Lowe, R.N.V.R., and Lieutenant E. F. Llarena, Suffolk Regiment.

Lieutenant Lowe joined the Royal Navy Volunteer Reserve some years ago as a Seaman, and before the War started, had worked his way up to the rank of Petty Officer. On the declaration of war, he was appointed Assistant M.O., with officer's rank, to the Armed Merchant Cruiser "*Macedonia.*" For six months he cruised about the Atlantic, and his ship figured in the naval engagement off the Falkland Islands.

On his return to England, he was promoted to Sub-Lieutenant, and on joining the Collingwood Battalion early in March, he was again promoted to be Lieutenant in the Royal Navy Volunteer Reserve. On May 12th he left England for the Dardanelles, where he fell in action.

Mr. CHARTERS SYMONDS, Consulting Surgeon to the Hospital, has been appointed consulting Surgeon, with temporary rank of Colonel, to H.M. Forces in the Mediterranean, and left for Malta a few days ago.

LIEUTENANT-COLONEL H. G. W. DAWSON wishes to bring to the notice of any Guy's men,

who are desirous of entering the Territorial R.A.M.C., the claims of the 2/1st North Midland Field Ambulance.

Through reinforcements having been sent out to the 1st line, which has been out for three months, there are now three vacancies. Only men desirous of foreign service are needed, and Lieutenant-Colonel Dawson will be glad to hear of or receive a visit from any gentlemen wishing to obtain a commission.

Field ambulance work is much more interesting to most men than that of Regimental Surgeon. Anyone requiring any further information on this subject should apply to Lieutenant-Colonel H. G. W. Dawson, 2/1st North Midland Field Ambulance, R.A.M.C., Dunstable.

It will interest all connected with Guy's to hear that No. 22 General Hospital is to be staffed as far as possible by Guy's men and nurses. So far Lieutenant-Colonel Maynard, Major Philip Turner, Lieutenants G. S. Miller, H. L. Attwater, F. C. Constant, H. Webb, and twenty Guy's nurses, whose names appear under Nursing News, are attached to it.

We feel certain that the appeal which the Matron has made in a letter in our Correspondence columns will meet with a hearty response.

The Staff Anæsthetists have very kindly sent us the following notice of the days on which they are willing to attend the Hospital, if their services are required:—

Mondays: Mr. Shipway, from 1.30 to 3.30, or later, if he is not wanted at King George's Hospital.

Alternate Tuesday Afternoons: Mr. Rowell.

Fridays: Mr. Page, provided his services are not required at King George's Hospital.

Mr. Page and Mr. Shipway have also promised to come down on other days if they are free, provided the House Officers make arrangements by telephone.

Those gentlemen who subscribed towards the Flint Fund will be pleased to hear that before Mr. Flint sailed for South Africa, the Secretary of the Dental Society presented him with a gold watch and a cheque of thirty pounds value. Mr. Flint wishes to convey his thanks and hearty appreciation of this parting gift, to all his well wishers.

The Gazette has suffered a great loss this week by the resignation of the Editor, Mr. W. E. Tanner. He took up this post in August, 1912, and, despite the strenuous work which his House Appointments involved, he has always published a Gazette full of interesting news and articles. We would like to voice the general opinion and accord him a hearty vote of thanks.

Hearty congratulations to A. L. Punch on obtaining the Gold Medal in Medicine.

Notices.

Metropolitan Asylums Board.

INSTRUCTION IN FEVERS.

A course of instruction (two months) in the diagnosis and treatment of fevers will be held during August–September, 1915, at the North-Western Hospital, Lawn Road, Hampstead, N.W., by J. MacCombie, M.D., Medical Superintendent, on Tuesdays and Fridays, at 2 p.m., beginning Tuesday, 3rd August.

Students who desire to attend this course of instruction must, before attending at the hospital, bring, between 11 a.m. and 4 p.m. on any week-day (except Saturday), or send by post, to the Clerk to the Metropolitan Asylums Board, Victoria Embankment, E.C.—(1) Authority from the Dean of the Medical School. (2) Fee: £3 3s. for two months' course. Cheques to be made payable to "The Metropolitan Asylums Board." (3) Full name and address, and name of Medical School. (N.B.—The name must be in full, and must be distinctly written.)

Note.—It must be distinctly understood that no certificate will be granted to any student who has attended for less than two days in each week during the whole period of two months.

By order,
T. DUNCOMBE MANN,
Clerk to the Board.

June, 1915.

The Clinical Research Association.

Memorandum on Epidemic Cerebro-spinal Meningitis and Laboratory Investigations in connection with that Disease.

EPIDEMIC cerebro-spinal meningitis (Spotted Fever) is an acute febrile disease (included by the Public Health Authorities amongst notifiable diseases) characterised by suppurative or fibrino-purulent leptomeningitis of the brain and spinal cord due to infection by the diplococcus meningitidis intracellularis of Weichselbaum. At present there is little exact information as to the portal of entry, and although many competent observers consider that it gains access to the subdural space directly from the post-nasal pharynx (through the ethmoidal cells), the disease will in all probability ultimately be found to resemble other acute specific fevers in that the micro-organism at first gains access to the general circulation, multiplies there for a time —during the incubation period—and finally becomes localised in its specially selected area, the spinal meninges. As in other acute specific fevers, the causative bacteria occasionally leave the body through the medium of the renal excretion. Moreover, as there is a growing belief that the disease is largely spread by "carriers," many health authorities require a bacteriological examination of mucus from the post-nasal pharynx of all contacts when a fresh case is notified.

The above-mentioned points serve to indicate the various lines of the laboratory research which may aid the practitioner who aims at exact diagnosis—a matter of no small importance, for the clinical symptoms are by no means pathognomic. For example, pneumococcic meninigitis, or one due to the streptococcus, may give rise to an exactly similar symptom-complex, including the hæmorrhages which give the disease its popular name, as may also meningitis due to B. typhosus or B. influenzæ, although "spots" are uncommon in the latter; whilst tuberculous meningitis, though more gradual and insidious in its onset, often displays many of the more striking clinical features of Spotted Fever.

The following notes on the collection of specimens of blood, cerebro-spinal fluid, urine, and post-nasal pharyngeal mucus for examination in the laboratory have been compiled in the hope that they may prove of use to practitioners during the present epidemic.

The apparatus required for the collection of any or all of these specimens may be obtained on application to the Secretary, Clinical Research Association, Watergate House, Adelphi, W.C.

BLOOD (IN FLUID CONDITION).

This may be examined during the prodromal stage for the presence of the specific micrococcus by means of cultivation experiment, and is best collected from the median basilic or median cephalic vein.

Apparatus Required.—All-glass anti-toxic syringe, 10 c.c. capacity, provided with stout *sharp* needle. Tourniquet. Sterile solution of sodium citrate, 1 per cent. in normal saline solution. Two tubes of nutrient gelatin. Ether. Cotton wool.

Preparation of Apparatus.—Sterilise the all-glass syringe by boiling, and let it cool in the tray of the steriliser. Do not transfer it to any antiseptic solution or distilled water. When cool, draw into the barrel a few cubic centimetres of the sterile sodium citrate solution so as to moisten the whole of the interior. Then expel the air and half of the citrate solution. Liquefy the gelatin by immersing the culture tubes in a glass containing *warm* water.

Preparation of the Patient.—Cleanse the skin at the bend of the elbow with cotton-wool soaked in ether. Compress the selected vein by means of the tourniquet above the bend of the elbow to render it prominent.

Method of Collection.—The operator, having disinfected his hands, should thrust the syringe needle, with the bevel of the point downwards, through the skin by the side of the vein. Then alter its direction slightly, and push it onwards so that it enters the lumen of the distended blood vessel in the direction of the stream, the syringe itself being held almost parallel to the skin so that it does not pass through the vessel and puncture its deeper wall.

The blood now flows into the syringe, being usually under sufficient pressure to drive the smoothly sliding piston in front of it, so that the barrel of the syringe is filled without the necessity for employing suction.

When the required quantity has been collected, remove the tourniquet, withdraw the needle from the vein and, if necessary, seal the skin puncture with collodion or a piece of strapping.

Eject the blood from the syringe, half into one tube of liquefied gelatin, the remainder into the second tube; in each case shake the mixture gently, care being taken not to let it run up to the plug. Resolidify the gelatin by placing the tubes into a glass of cold water for some minutes, after which it is ready to pack and forward to the Laboratory.

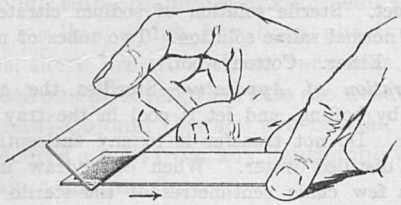
BLOOD (DRIED FILMS).

A leucocytosis giving a differential count characterised by a high proportion of polymorphonuclear leucocytes is such a constant feature of the disease, and contrasts so sharply with the mononuclear leucocytosis of tuberculous meningitis, that its absence is generally regarded as sufficient proof that the case under consideration is not meningococcic.

Apparatus Required.—Grease-free slides. A needle. Rubber bands. Box.

Method of Procedure.—Clean the lobe of the patient's ear with ether, or soap and water, rub dry, and prick sharply with the needle. Bring the surface

of one slide in contact with the resultant blood-drop so as to get some of it near one end. Lay the edge of a second slide transversely across the first in the way indicated in the following diagram:—



and push the transverse slide steadily along the surface of the horizontal one to the other end of the latter. The blood-drop should be on the distal side of the transverse slide, so that it is *drawn* along by the latter and not *pushed* along by it. The film should be as thin as possible, drying in a few seconds.

Prepare three such slides, allow them to dry completely, wrap them *separately* in tissue paper, fasten together with elastic bands to prevent rubbing, and replace them in the box. It is of the utmost importance that the blood films be allowed to dry completely before they are repacked.

CEREBRO-SPINAL FLUID.

The identification of the meningococcus in the cerebro-spinal fluid is an essential feature in the diagnosis, and the procedure by which material is collected for examination is known as "lumbar puncture." It consists in withdrawing fluid from the subarachnoid space after puncturing the membranes of the spinal canal with a hollow needle, passed between the laminæ of two contiguous lumbar vertebræ. As a rule, no anæsthetic is needed; at most, some local anæsthetic such as ethyl chloride is all that should be employed.

A.—*Apparatus Required.*

1. Sterile all-glass serum syringe, fitted with stout, strong, and sharp needle, fully six or seven centimetres long; indeed, in the case of an obese adult a needle nine centimetres in length may be needed, and one millimetre in bore.
2. Sterile test-tube fitted with rubber stopper, to receive the cerebro-spinal fluid when collected.
3. 2 per cent. solution of lysol, for disinfecting site of puncture.
4. Drop bottle of ether, for disinfecting site of puncture.
5. Sterile gauze or cotton wool swabs.
6. Flexile collodion and cotton wool.
7. Spray tube of ethyl chloride.

B.—*Preparation of the Patient.*

1. After deciding on which side of the mesial line to make the puncture, arrange the patient in bed in the semi-prone position on whichever side is the more convenient to the operator; bend the knees and flex the thighs on the abdomen so that the lower part of the vertebral column is well arched; raise the head slightly on a pillow. Instruct the nurse, or other assistant, to hold the patient firmly in this position at the moment the puncture is made. Adjust either the bed or the illuminant so that the field of operation is well lighted.

2. Identify the spinous process of the fourth lumbar vertebra either by counting the processes downwards from the twelfth dorsal, or by the help of a line joining the highest points of the iliac crests (which crosses the process required). From this point as a centre (and in the case of a stout person it may be useful to mark it by a spot of Tincture of Iodine), mentally map out a circular area of some ten centimetres diameter.

3. Cleanse the skin over this area by washing thoroughly with several changes of lysol solution; remove the lysol by repeated applications of ether from the drop bottle; scrub the skin thoroughly with a sterile swab of cotton-wool, or gauze saturated with ether. Finally, flush the area with more ether, cover it with a pad of sterile gauze, and allow the ether to evaporate whilst the hands of the operator are thoroughly disinfected *secundum artem*, and encased in sterile rubber gloves.

C.—*Collection of the Fluid.*

1. Now mark the position of the spinous processes of the third and fourth lumbar vertebræ by the tips of the forefinger and thumb of the left hand, at the same time steadying the skin covering the interspace.
2. The skin covering the site selected for puncture should now be frozen, if desired.
3. Remove the syringe and needle from the steriliser, take the instrument in the right hand, and hold as a bradawl would be held.
4. Enter the point of the needle opposite the centre of the space marked by the finger and thumb of the left hand, about half a centimetre outside the mesial line of the back. Press the needle vertically forwards until the point strikes against bone, the upper border of the lamina of the fourth lumbar.
5. Withdraw the needle a few millimetres, move the barrel of the syringe so as to direct the point of the needle slightly upwards and at the same time slightly inwards, then drive the needle steadily onwards until that creaking sensation is experienced which marks the passage of the needle through the ligamentum subflavum.
6. Depress the barrel of the syringe, and remove the palm of the hand from the head of the piston.

If the spinal canal has been entered, fluid will now commence to flow into the barrel of the syringe, partly as the result of intra-spinal pressure, partly by reason of the very slight suction exercised by the weight of the smoothly-sliding glass piston.

If the fluid collects rapidly in the barrel, indicating high intra-spinal pressure, raise the syringe slightly in order to retard the flow, *as cerebro-spinal fluid*

should be collected slowly. Sometimes it is impossible to obtain more than a few drops of fluid; usually from ten to fifteen cubic centimetres can be readily secured.

7. If no fluid appears, gently rotate the syringe and its needle, as the needle may have pushed the spinal meninges forward instead of piercing them. If still "dry," then apply very gentle traction to the piston, but if perchance the end of the needle is blocked by a nerve filament, this step will fail to have the desired effect. If, therefore, no fluid shows itself, withdraw the needle almost completely, and make another attempt, this time giving a slightly different direction to the needle.

8. If still unsuccessful, a similar puncture may be tried in the corresponding spot on the opposite side of the mesial line, or in the interval between the second and third lumbar vertebræ.

9. When sufficient fluid has been collected, withdraw the needle, and seal the puncture with a collodion dressing.

10. Remove the rubber stopper from the sterile test-tube, and squirt the contents of the syringe into the test-tube and re-stopper the latter securely.

Pack it into its postal case, and return to the laboratory without delay.

MUCUS FROM THE VAULT OF NASO-PHARYNX.

The method for obtaining this material is as follows, always remembering that two matters are of prime importance in this connection :—

a. Owing to the similarity of the meningococcus to several less harmful micro-organisms normally present in the mouth, it is important that the swab should be as free as possible of contamination with saliva, and should, in fact, only come into direct contact with the vault of the naso-pharynx.

b. As the meningococcus readily dies on the swab, it is desirable to make the cultures as quickly as possible, and with a view to avoidance of contamination by saliva, a special covered swab such as that introduced by Wyatt Wingrave is most suitable, and can be obtained ready sterilised on application to the Secretary, Clinical Research Association.

1. Seat the patient facing a good light.

2. Remove the cotton-wool plug from the short up-curved end of the swab tube, and return the tube to the right hand.

3. Instruct the patient to open his mouth as widely as possible, and depress his tongue with a spatula held in the left hand.

4. During the phonation, pass the covering tube with the swab *in situ* behind the soft palate, then extrude the swab so as to bring it into contact with the roof of the naso-pharynx, draw back the swab into the covering tube, and remove the instrument from the patient's mouth.

5. Replug the plug in the curved end, pack the tube containing the swab, and return it to the laboratory without delay.

Guy's Hospital.

The following Appointments and Re-appointments have been made by the President on the recommendation of a Staff Meeting :—

MEDICAL SCHOOL.

Dean of the Medical and Dental Schools.—Mr. L. Bromley.

Greville Lecturer on Pharmacology (War appointment).—Dr. Laidlaw.

Medical Registrars.—Drs. Mutch, Barber, and Heaton.

Surgical Registrars and Demonstrators of Anatomy.—Messrs. Todd and Mullally.

Surgical Registrar (War appointment).—Mr. Tanner.

Ophthalmic Assistants.—Messrs. Bookless and Ryley.

Obstetric Assistant.—Mr. Pochin.

Demonstrator of Operative Surgery.—Mr. Bromley.

Demonstrators of Anatomy (War appointments).—Messrs. F. D. Saner and Zamora.

Demonstrator of Physiology.—Mr. G. Marshall.

Demonstrators of Chemistry.—Messrs. Merriman and Rogerson.

Demonstrator of Physics.—Mr. H. H. Abram.

Demonstrator of Biology.—Mr. T. Reed.

Lecturer on Chemical Pathology.—Mr. Ryffel.

Lecturer on Clinical Microscopy.—Dr. Nicholson.

Douglas Demonstrator of Pathology.—Dr. Goodhart.

Senior Medical Radiographer.—Dr. Lindsay Locke.

Assistant Surgical Radiographer.—Mr. Eccles.

The following Appointments and Re-appointments for 1915–16 have been made by the President on the recommendation of a Staff Meeting :—

DENTAL SCHOOL.

Lecturer of Dental Materia Medica.—Mr. E. B. Dowsett.

Demonstrator of Prosthetic Dentistry.—Mr. H. L. Messenger.

Demonstrators of Practical Dentistry with charge of Revision Classes.—Messrs. F. N. Doubleday and G. B. Pritchard.

Demonstrators of Practical Dentistry with charge of Probationary Classes.—Messrs. W. S. Stranach and L. D. Wright.

Demonstrator of Practical Dentistry with charge of Extraction Classes.—Mr. L. Price Harris.

Demonstrators of Dental Microscopy.—Messrs. H. C. Malleson and G. Marshall.

Demonstrator of Orthodontics.—Mr. F. B. Bull.

Demonstrator of Practical Dentistry with charge of Probationary Classes.—Mr. W. K. Fry.

Demonstrator of Dental Microscopy (War appointment).—Dr. Pembrey.

Demonstrator of Practical Dentistry with charge of Revision Classes.—Mr. F. N. Doubleday (War appointment).

Curator of Dental Museum.—Mr. E. B. Dowsett.

Resident Dental Officer.—Mr. F. B. Bull.

A Case of Perforated Gastric Ulcer in a Girl of 15.

ELIZABETH F., æt. 15, was admitted into Martha Ward on April 17th, under Sir Arbuthnot Lane, for acute abdominal pain and vomiting. Patient had lived in Bermondsey all her life, had always been a strong healthy girl, and had never suffered from constipation.

In August last she began to have severe attacks of pain in the epigastric region, which attacks came on half an hour after meals and continued for an hour to an hour and a half. The pain was often accompanied with vomiting, patient noticing nothing particular about the vomit. Her appetite failed and she began to look thin and anæmic. The attacks of pain and vomiting continued off and on until April 17th when patient had a sudden sharp pain in the epigastric region, gradually spreading all over the abdomen and up as far as both shoulders. Her doctor was called in, diagnosed acute appendicitis with peritonitis, and sent her up to the hospital.

When seen in the surgery patient was in rather a collapsed condition and complained of little or no pain. Her tongue was furred and dry and her expression anxious. The abdomen was uniformly rigid, and there was some cutaneous hyperæsthesia on the right side. Temperature 100·6°, pulse 128, respiration 32.

Mr. Fagge operated under A.C.E. followed by open ether, the patient being infused with four pints of saline during the operation. A six inch right paramedian abdominal incision was made and the peritoneal cavity opened. There was a large amount of dirty yellow fluid present, which was quite odourless, and remained sterile after three days' incubation at 37°C. The appendix was examined, found normal, and not removed, so the incision was then carried upwards. Gall-bladder, duodenum, and kidneys were in turn examined and found normal, and finally a small perforating ulcer was found on the anterior wall of the stomach close to the lesser curvature and nearer the pylorus than the cardia. The ulcer and surrounding tissues were invaginated with a catgut suture, and the abdominal cavity was then perfused with saline. The wound was closed layer by layer, and a large rubber drainage tube was left in the pelvis.

Patient was rather weak the following morning—temperature 98·8°, pulse 128, respiration 42—and she was infused with a further four pints of saline. At the end of 48 hours the drainage tube was omitted, there having been little or no discharge from the peritoneal cavity. Patient was propped up in a sitting position and kept on fluid diet for the first few days, and was then given light diet. She rapidly improved, though for two days she had an evening temperature of 100°—101°, probably due to a slight wound suppuration which cleared up after being treated with boric fomentations followed by Wright's solution. At the end of three weeks patient looked and felt quite well and was discharged to a convalescent home.

One of the most interesting features of this case is the youth of the patient. Sydney Martin states that out of 171 cases, only 15 occurred before the age of 20. On looking up the reports of 43 surgical and 78 clinical and medical ward cases of Guy's, it appears that perforation of gastric ulcer took place according to the following table:—

Years.	Males.	Females.
0—20 ...	0 ...	12
20—25 ...	9 ...	16
25—30 ...	5 ...	10
30—40 ...	13 ...	9
40—50 ...	19 ...	6
50—69 ...	14 ...	8
Total	60	61

In these cases the perforation was verified either by operation or post-mortem; 65 died and the re-remainder made more or less complete recoveries. About 30 of the cases were wrongly diagnosed, among the diagnoses being lead colic, ruptured tubal gestation, perforated appendix abscess, general peritonitis, uræmia, intestinal obstruction, suppurative growth, and early pneumonia.

Calwell, in the *British Medical Journal*, January 5th, 1907, says that there are apparently two kinds of gastric ulcer: one, connected with chlorosis and amenorrhœa, probably being a developmental disease and forming and healing with great rapidity; and the other being a type occurring equally in men and women, not often seen till after twenty and tending to become chronic.

The present case appears to belong to the first type which is often undiagnosed unless actual perforation takes place. In conclusion, I wish to thank Mr. Fagge for permission to publish this case.

M. B. M. TWEED.

Pass List.

Royal College of Surgeons of England.

LICENCE IN DENTAL SURGERY.

FINAL EXAMINATION.

June, 1915.

*W. P. Barfoot.
*G. F. H. Bloom.
L. H. Cross.
E. A. Dawson.
*G. Deeks.
L. Machin.
*P. R. C. Martin.
*L. A. Morris.
L. S. Pilbeam.
P. L. Schalkwijk.
*S. G. Smith.
*G. M. Thomas.
*H. L. Thorn.
F. H. Wallace.
*M. G. Watson.
*R. G. Wilshire.
W. J. R. Viljoen.

*Part I. only.

Appointments.

Medical School Appointments.

JULY–SEPTEMBER, 1915.

Clinical Assistants (August–October)—Messrs. C. H. Medlock, D. H. A. Galbraith, J. G. Jones.

Dressers and Clerks in Special Departments:—

Throat and Ear, Genito-Urinary, and Children.—Messrs. P. G. McEvedy, I. R R. Brogden, D. V. Halstead.

Throat and Ear, Skin, and Orthopædic.—Messrs. S. Wacher, W. J. Vance, W. B. Buer.

Eyes and Nervous System.—Messrs. G. E. L. Simons, H. J. Bensted (Mr. Eason); H. M. Gray (Mr. Ormond).

Obstetric Dressers and Externs.—Messrs. G. Noott, (Mr. G. Bellingham Smith); E. N. Glover, K. M. Woodruff, D. M. P. Whitcombe (Mr. Chapple).

Externs only.—W. G. S. Neely, A. F. G. Guinness.

Obstetric Dresser only.—Mr. W. H. A. Pratt (Mr. Bellingham Smith).

Medical Ward and Post-Mortem Clerks.—Messrs. H. E. Bamber, R. S. Millar, S. Vidôt, J. E. de Robillard (Dr. Hale White); T. L. Heath, A. W. A. Davies, W. Burridge (Dr. Shaw); G. W. Heckels, J. H. H. Campbell, H. St. H. Vertue (Dr. Fawcett); C. L. Odam, M. B. M. Tweed, J. T. T. Forbes (Dr. Beddard).

Medical Ward Clerks.—L. Gill, E. H. Bryant, H. D. Apergis, E. F. Deacon, E. C. Hinde, F. R. Leblanc, H. N. Pritchett, G. R. Hubbard.

Surgeons' Dressers.—Messrs. G. E. Kidman, F. N. Sidebotham, H. I. Sterne Howitt (Sir W. A. Lane); T. E. Micklem, R. R. Traill, E. S. Phillips, E. A. Leviseur (Mr. Dunn); L. S. Gathergood, A. M. Ahmad, P. D. Chapman (Sir A. Fripp); B. E. Jerwood, R. H. C. Pryn, I. Tewfik, M. C. Joynt (Mr. Steward).

Assistant Surgeons' Dressers.—Messrs. R. Aspinall-Stivala, J. O. R. Montocchio (Mr. Fagge); B. Ramirez, J. C. C. Howe (Mr. Rowlands); L. B. Moore (Mr. Trethowan); S. W. F. Underhill, O. St. L. Campion (Mr. Hughes).

Surgical Ward Clerks.—Messrs. E. Creed, S. M. M. Jabir.

Naval.

To be temporary Surgeon:—E. J. Tongue.

Royal Army Medical Corps.

Charters J. Symonds, M.S., M.D., F.R.C.S, has been appointed Consulting Surgeon to His Majesty's Forces, with the temporary rank of Colonel, Army Medical Service, and has left for Malta.

Lieut. L. U. Ransford to be Captain, 2/5 Essex Regiment, T.F.

H. Chapple, M.C., F.R.C.S., to be Surgeon, Fulham Military Hospital.

L. Bromley, M.C., F.R.C.S., and F. D. Saner, M.B., B.C., to be Surgeons to Lewisham Military Hospital.

To be temporary Lieutenants:—G. N. Mottram, H. Webb, N. Instone, R. H. Ashwin, G. H. Russell, H. L. Attwater, S. F. Holloway, E. F. Clowes, R. D. Mothersole, C. C. G. Gibson, F. W. Fawssett, H. S. Groves, H. D. Smart, G. W. Dryland, F. J. Wheeler, G. Clarke, A. H. Clough, G. Hamilton, E. G. Goldie, C. R. Lucas, E. Coleman, A. E. Clarke, M. Abdy Collins, L. W. Evans, D. Allan.

Welsh Casualty Clearing Station:—Lieut. John E. Biggs, from attached to others than Medical Units, to be Lieutenant.

Capt. John M. Fortescue-Brickdale is seconded for service with the Expeditionary Force.

To be Army Dentists with the rank of temporary Lieutenant:—A. B. W. Rust, for service abroad. Douglas Wain, for service at home.

Civil.

Edward C. B. Ibotson, M.D., B.S. Lond., has been appointed Certifying Surgeon under the Factory Act for the Civil Parish of Talyllyn, and part of Machynlleth Rural District.

D. H. Forty has been appointed Acting Medical Officer for the Charfield District by the Thornbury (Gloucestershire) Board of Guardians.

W. E. Tressider, M.B., B.S. Lond., has been appointed Medical Officer to the Scattered Homes for Children, by the St. Germans (Cornwall) Board of Guardians.

A. H. Tubby, M.S., F.R.C.S., has been elected an Honorary Member, with medal of the First Class, of the Societa Fisico-Clinico Italiana.

B. T. Verver, M.R.C.S., L.R.C.P., to be District Medical Officer of the Basford Union.

Indian Medical Service.

Major J. H. Horton, D.S.O., I.M.S., D.A.D.M.S., 12th Indian Division, Indian Expeditionary Force "D," c/o India Office, Whitehall, S.W.

Mentioned in Dispatches.

I.M.S.

Major R. M. Barron, 113th Indian Field Ambulance.
Capt. C. H. Reinhold, 111th Indian Field Ambulance.

R.A.M.C.

Col. F. F. Burghard.
Major R. T. Brown.
Capt. W. H. S. Burney.
Capt. M. Coplans (T.F.)
Major S. L. Pallant.
Temp. Lieut. P. Smith.
Lieut. Capt. O. Richards.

CIVIL HOSPITALS RESERVE.

Miss V. M. Kiddle.

ARMY CHAPLAIN'S DEPARTMENT.

Rev. A. E. Popham, Temporary Chaplain to the Forces, 4th Class, Medical Service and R.A.M.C.

Honours.

C.B.—Col. F. F. Burghard.
C.M.G.—Lieut.-Col. J. C. B. Statham, R.A.M.C.
D.S.O.—Capt. O. Richards, R.A.M.C. (temporary)
Military Cross.—Lieut. (temporary) P. Smith.

Visceroptosis.

CLINICAL LECTURE BY ARTHUR F. HERTZ, M.D.

GENTLEMEN,—The maintenance of the normal position of the viscera in different postures depends upon (1) the proper development of the thorax, and (2) an adequate intra-abdominal pressure.

(1) *Insufficient development of the thorax.*—This is not infrequently congenital, especially in females; it may also result during the period of growth from disorders of nutrition, especially rickets, from thoracic diseases, particularly those leading to fibroid lung, and from insufficient exercise. As the thorax is long and shallow, with very oblique ribs and a narrow epigastric angle, the thoracic part of the abdomen is abnormally small, and the liver, spleen and kidneys, and the part of the stomach which is normally hidden beneath the ribs, together with the colon, are displaced downwards. The displacement of organs or part of organs, which are already below the umbilicus, is increased by tight corsets and belts.

(2) *Deficient intra-abdominal pressure.*—The most common cause of visceroptosis is a diminution in the intra-abdominal pressure. The viscera are normally kept in position by the slight positive intra-abdominal pressure, which is maintained by the tonic contraction of the muscles of the abdominal wall and the pelvic floor, their peritoneal attachments remaining slack. The position of the diaphragm also depends in part upon the difference between the negative intra-thoracic pressure and the positive intra-abdominal pressure; if the latter is reduced for any reason, the diaphragm and the organs which are attached to it descend when the vertical position is assumed.

A fall in intra-abdominal pressure is most frequently due to weakness of the abdominal and pelvic muscles. The tone of the abdominal muscles is often impaired by the stretching, which they undergo during pregnancy and which also results from ascites, large abdominal tumours and the accumulation of abnormal quantities of subperitoneal and omental fat. In such cases the muscular covering of the abdomen may also become incomplete owing to separation of the rectus muscles. After parturition or the removal of ascites by paracentesis, the sudden diminution in the volume of the abdominal contents is so great that a considerable fall in intra-abdominal pressure occurs, as the stretched muscles are at first very lax. If the patient remains in bed for a sufficient period they gradually regain their tone, and the separated recti come together again. When, however, too little attention is paid to the condition of the abdominal muscles after parturition, as is frequently the case with the poor, and especially if pregnancy is often repeated, they become permanently weakened.

Weakness of the abdominal muscles is common among people who take too little exercise owing to a sedentary occupation, laziness or obesity. Atrophy and degeneration of the abdominal muscles are also produced by malnutrition in rickets, anæmia and prolonged fevers.

The pelvic floor consists of a muscular diaphragm, which is formed by the levator ani together with other less important muscles, and is strengthened above and below by a layer of fascia. The harm done by parturition consists less in any actual tearing than in a general atrophy of the levator ani muscles, which is due to overstretching and to ischæmia from the long-continued pressure of the fœtal head during difficult labour.

The anus is normally slightly retracted; the retraction is increased and the anus moves slightly forward when the levator ani muscles are contracted. If they are weak the retraction in the condition of rest is absent or less than normal, and on contracting the levator ani muscles the retraction and forward movement are slight or absent. If the levator ani muscles are weak, on straining or making a bearing-down effort, the whole perineum projects much further than it should do, even if no actual prolapse is produced. Although parturition is the only cause of serious weakness of the levator ani muscles, a mild degree is frequently associated with the weak abdominal muscles of individuals who lead a sedentary life.

Even when the abdominal and pelvic muscles are strong, the diminution in the bulk of the abdominal contents caused by the disappearance of the normal intra-abdominal fat, when for any reason a condition of emaciation develops, results in a fall of intra-abdominal pressure and consequently in visceroptosis. I have seen several cases in which visceroptosis, often accompanied by serious digestive symptoms, immediately followed the removal of a pelvic tumour, particularly an enlarged uterus, the intestines dropping into the position previously occupied by the tumour.

Effect of posture on visceroptosis.—When the contents of the thoracic abdomen are displaced

downwards owing to its insufficient development, the viscera drop no more than those of normal individuals on assuming the vertical position. When, however, visceroptosis is due to low intra-abdominal pressure, the viscera drop directly gravity comes into play, but at first they regain their normal position as soon as the patient lies down. At a later stage, when the daily descent of the viscera has continued for a considerable time, the displacement persists in the horizontal position.

The degree of ptosis of the different organs depends upon their weight and upon the length and elasticity of their peritoneal attachments, which, in the absence of their natural support, act as true ligaments. Thus the stomach only drops when it is full, gastroptosis being favoured by habitual over-eating and over-drinking, particularly when the organ is also atonic. The discomfort which may occur depends more upon the quantity than the quality of the food; thus milk produces just as much disturbance as an equal weight of solid food. The fundus of the stomach, being closely attached to the diaphragm, cannot drop away from it; the pylorus is prevented from descending as far as the greater curvature because of its proximity to the fixed part of the duodenum, though in some cases the duodenum also becomes loose and drops with the pylorus.

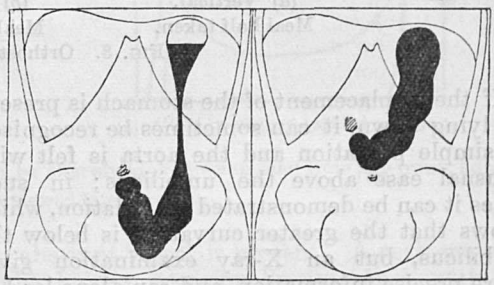
The colon drops farthest when it is loaded as a result of chronic constipation. When stasis occurs particularly in the cæcum and ascending colon, these parts are constantly full and heavy instead of being empty from about 2 a.m. until four hours after breakfast; an abnormally moveable cæcum is particularly likely to drop into the pelvis in such cases. When, on the other hand, no stasis occurs before the transverse colon is reached, but an abnormal quantity of solid fæces accumulates in this part of the bowel, the cæcum may be normal in position but the transverse colon drops into the pelvis, its longitudinal muscle-fibres are abnormally stretched and some kinking may occur at the fixed splenic flexure, so that the stasis is likely to become increased. Lastly, a large and heavy accumulation in the pelvic colon causes it to drop unduly, and partial obstruction at the pelvi-rectal flexure may result.

Very movable organs, such as the small intestine and the transverse colon, drop most readily, and the loosely-attached hepatic flexure almost always descends considerably further than the firmly attached splenic flexure, though I have seen cases of severe ptosis of the latter, due apparently to congenital ill-development of the phreno-colic ligament. The kidneys are most likely to drop when the fat, which normally surrounds them and helps to keep them in position, is deficient in quantity.

Symptoms.—The symptoms present when visceroptosis is due to an ill-developed thorax are not so much caused by the ptosis as by the general condition of malnutrition which is frequently present. The following description, therefore, applies more particularly to the form due to low intra-abdominal pressure. Most of the symptoms of visceroptosis occur only when the erect position is assumed. They consequently disappear on lying down and are absent at night; they are temporarily relieved when the lower part of the abdomen is compressed by means of the hand, and in women they frequently show a steady improvement as pregnancy advances, owing to the rise in intra-abdominal pressure and the support given to the viscera by the growing uterus.

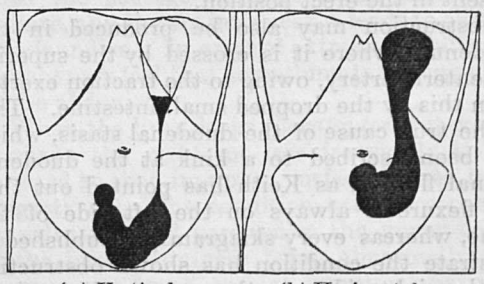
The symptoms have been ascribed in turn to the kidney, stomach, intestines or uterus, according to which happened to be the special object of study. It is probable, however, that the general effects are commonly of more importance than those due to ptosis of individual organs.

Results.—*Gastroptosis* is present if the lesser curvature of the stomach is below the umbilicus in the erect position (Figs. 1 and 2). It does



(a) Vertical. *(b)* Horizontal.

FIG. 1. Gastroptosis.

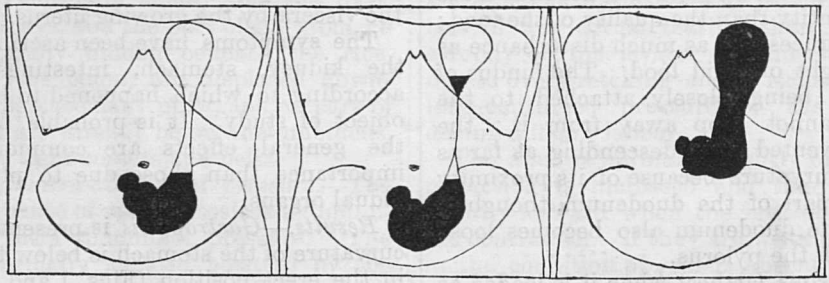


(a) Vertical. *(b)* Horizontal.

FIG. 2. Gastroptosis, leading to "Orthostatic" hour-glass constriction, which disappears on lying down.

not lead to kinking of the pylorus, which, together with the first part of the duodenum, is surrounded by peritoneum and freely movable, but in severe cases a kink is produced at the fixed point between the first and second parts of the duodenum, except when the whole duodenum slides down behind the peritoneum. The kink delays evacuation, as shown with the X-rays by the delay in the first part of the duodenum and by the presence of barium in the stomach six hours after an opaque meal, and painful digestion, which is relieved by lying down and varies with the bulk but not with the nature of the food, results. Apart from this no symptoms occur unless the ptosis is associated with atony, when the symptoms due to the latter are exaggerated, and an hour-glass constriction forms in the erect position owing to the drag of the dependent part of the stomach on its central part (Fig. 3).

Ever since Glénard drew attention to the condition he called *enteroptosis*, it has generally been supposed to produce kinks of the intestines, especially at the flexures of the colon, which give rise to obstruction to the onward passage of fæces, and a pelvic cæcum and a dropped transverse colon are often referred to as if they were invariably associated with constipation. I believe, however, that in a large majority of cases they are quite independent conditions. I have certainly seen a pelvic cæcum in almost as large a proportion of strong healthy individuals with perfect digestion and no constipation as of constipated patients. Moreover, I have only occasionally been able to convince myself, when a pelvic cæcum was associated with constipation, that there was any causal relationship between the two conditions, as in the majority of cases dyschezia without delay in the cæcum or in any other part of the colon was present;



(*a*) Vertical. Meal half taken. (*b*) Vertical. Meal completed. (*c*) Horizontal.

FIG. 3. Orthostatic hour-glass stomach.

If the displacement of the stomach is present on lying down, it can sometimes be recognised by simple palpation and the aorta is felt with unusual ease above the umbilicus; in such cases it can be demonstrated by inflation, which shows that the greater curvature is below the umbilicus, but an X-ray examination gives more precise information, and can alone lead to a correct diagnosis when the ptosis is only present in the erect position.

Obstruction may also be produced in the duodenum, where it is crossed by the superior mesenteric artery, owing to the traction exerted upon this by the dropped small intestine. This is the true cause of the duodenal stasis, which has been ascribed to a kink at the duodeno-jejunal flexure, as Keith has pointed out that the flexure is always on the left side of the spine, whereas every skiagram yet published to illustrate the condition has shown obstruction on the right side, exactly corresponding to the position of the superior mesenteric artery.

quite exceptionally the descent of the cæcum may have been favoured by the stasis which was found to occur in it and in the ascending colon.

In a skiagraphic study of fifteen normal young men, carried out in 1908, which has since been confirmed by numerous other observations, Dr. C. J. Morton and I found that in the vertical position the lowest part of the transverse colon is almost invariably situated well below the umbilicus, even when the stomach is empty. In normal individuals examined with the x-rays the hepatic and splenic flexures often appear to be acutely kinked (Fig. 4 (*a*)). This is the result of the shadow being cast in a single plane, as the limbs of the flexures belonging to the transverse colon are in front of those of the ascending and descending colon respectively, and the flexures appear to be acute, although they form a wide angle when looked at from the side (Fig. 4 (*b*)).

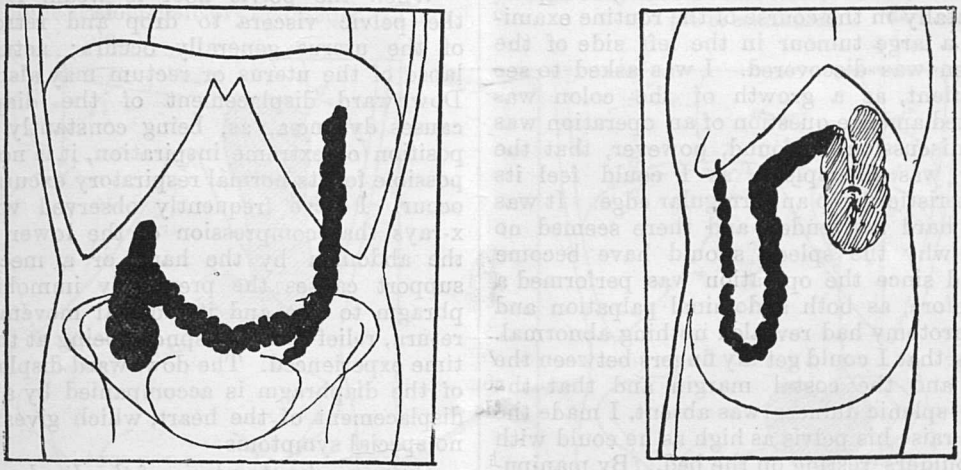
If visceroptosis caused obstruction at the intestinal flexures, the constipation would be

associated with colic. But although much discomfort is often present in such cases, colic is rare, and strong contractions of the intestines are never either visible or palpable. Moreover, chronic partial obstruction due to cancer and other causes leads to hypertrophy of the intestinal musculature above the obstruction, but in operations and autopsies on cases of visceroptosis no hypertrophy is ever found, and in some cases I have seen atrophy of the intestinal musculature.

The constipation, which is so often associated with visceroptosis, is generally due to weakness of the abdominal and pelvic muscles and the ptosis of the diaphragm, which render the act of defæcation inefficient, so that the rectum and pelvic colon are never properly emptied.

It is sometimes possible to recognize the presence of coloptosis by palpation, but accurate knowledge concerning the position of the colon and the passage of fæces through it can only be obtained by the x-rays; they are essential for the recognition of the numerous cases in which coloptosis is only present in the vertical position. The characteristic bulging of the lower part of the abdomen and retraction of the epigastrium seen on standing is due mainly to the ptosis of the small intestine; it is often completely absent in cases of severe gastroptosis and less frequently in cases of coloptosis.

In the majority of cases a moveable kidney gives rise to no symptoms, but in about one-tenth of the cases they may arise from obstruction of the ureter or blood-vessels, especially if



(*a*) View from in front. (*b*) View in antero-lateral position.

FIG. 4. Hepatic and splenic flexures, which appeared to be sharply kinked when seen from the front, but proved to be round when viewed laterally.

Ptosis of the transverse colon never leads to kinking at the hepatic flexure, which invariably drops with it, but a very moveable right kidney may produce obstruction in such cases. A definite sharp kink is occasionally produced at the splenic flexure, as the phreno-colic ligament is stronger than any other of the intestinal attachments. A dragging pain together with a sense of distension is then often felt in the left hypochondrium. In one of my cases, upon whom Mr. Steward operated, the kink was so marked that a short-circuiting operation was required, and the transverse colon, which was situated low down in the true pelvis, was anastomosed with the pelvic colon, with which it was already in contact.

an aberrant vessel is present. A very movable right kidney occasionally interferes with the evacuation of the stomach and more frequently with the passage of fæces round the hepatic flexure, and in rare instances it leads to obstructive jaundice. In cases of extreme mobility the patient may feel that something is moving about in the abdomen.

When the liver drops (*hepatoptosis*) it rotates towards the right, or less frequently it falls forward so that its upper surface bulges in the epigastrium. The condition can be recognised by palpation and percussion, the upper border of the hepatic dulness being abnormally low. It gives rise to no special symptoms beyond a vague pain in the right hypochondrium, which

may radiate towards the shoulder; it is increased by jumping, walking and coughing and disappears on lying down. The bile channels in the gastro-hepatic omentum may be compressed and gall-stones result from the resulting stagnation of bile.

A *dropped spleen* can be easily recognised by palpation; it generally gives rise to no symptoms, but in very rare instances great pain is produced by twisting of its pedicle.

Case of movable spleen.—A man of 40 was operated upon for acute cholecystitis; the whole of the abdomen was carefully examined, but nothing else abnormal was found. The gall-bladder was drained and for a year he was perfectly well. He then consulted his doctor on account of an attack of bronchitis, and quite accidentally in the course of the routine examination a large tumour in the left side of the abdomen was discovered. I was asked to see the patient, as a growth of the colon was suspected and the question of an operation was under discussion. I found, however, that the tumour was the spleen, as I could feel its characteristic sharp and irregular edge. It was neither hard nor tender, and there seemed no reason why the spleen should have become enlarged since the operation was performed a year before, as both abdominal palpation and the laparotomy had revealed nothing abnormal. Finding that I could get my fingers between the spleen and the costal margin and that the normal splenic dulness was absent, I made the patient raise his pelvis as high as he could with his shoulders resting on the bed. By manipulation I then managed to hide the spleen almost completely under the costal margin, from which it fell as soon as he lay down. We were thus able to convince ourselves that the spleen was not enlarged but had simply become extremely movable, and that on dropping from the diaphragm it rotated round a horizontal axis, so that its upper surface was directed forwards. A splenic mesentery had probably existed from birth, and the ptosis occurred as a result of the extreme atony of the abdominal muscles which had followed the illness and operation a year before.

A somewhat similar case was a woman of sixty, who was sent to me on account of a tumour, which she had herself accidentally discovered in the left side of her abdomen; it caused her no inconvenience of any sort. It was clearly not a growth of the colon, as a tumour of that size would be certain to produce more serious symptoms and there would be evidence of at any rate partial obstruction. It seemed to be about the size of a kidney, but the sharp anterior border excluded a moveable normal kidney and its shape made it unlikely that it was a growth of the kidney, as in such a case the kidney generally maintains its normal shape, and there had been no urinary symptoms. There seemed indeed no doubt that it was an exceptionally movable but otherwise normal spleen, and its size, consistence and shape corresponded with this diagnosis. On getting the patient to raise her pelvis very high I manipulated the tumour without difficulty back into the normal position, in which it remained for at any rate half an hour, so that it was quite impossible to feel it again, even when she had stood up.

When the pelvic floor is weak, it allows the pelvic viscera to drop and retroflexion of the uterus generally occurs; actual prolapse of the uterus or rectum may also result. Downward displacement of the diaphragm causes dyspnœa, as, being constantly in the position of extreme inspiration, it is no longer possible for its normal respiratory excursions to occur. I have frequently observed with the x-rays that compression of the lower part of the abdomen by the hand or a mechanical support causes the previously immobile diaphragm to rise and its normal movements to return, relief to the dyspnœa being at the same time experienced. The downward displacement of the diaphragm is accompanied by a similar displacement of the heart, which gives rise to no special symptoms.

Dyspnœa due to ptosis of the diaphragm in a case of general visceroptosis—A lady, aged 50, had suffered for a long time from neurasthenic symptoms accompanied by indigestion and shortness of breath. An X-ray examination showed that she had an "orthostatic hour-glass stomach," the contraction being due to the drag upon the centre of the stomach in the erect position, as it disappeared when she lay down. In the horizontal position the diaphragm was normal, and its respiratory excursion was 2½ in. (Fig. 5.) In the erect position it dropped almost into the position of extreme inspiration, so that even with a great effort it only decended ¼ in. Consequently diaphragmatic respiration was impossible in the erect position, though normal on lying down. The abdominal muscles were exceedingly feeble, the visceroptosis being clearly due to this. When she was given an abdominal support, the diaphragm was pushed up, so that the normal respiratory excursion became possible, and the dyspnœa disappeared.

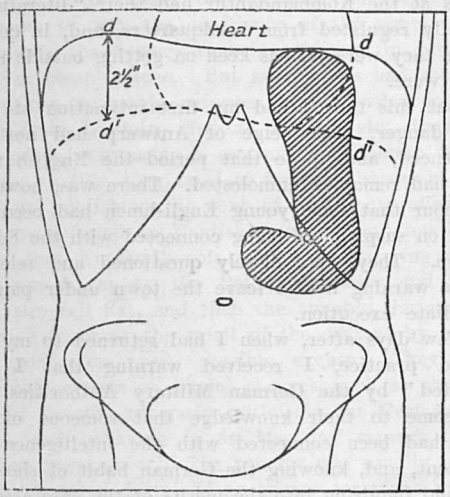
I believe that a similar condition is not an uncommon cause of dyspnœa in individuals with weak abdominal muscles. Many patients suffering from heart failure, who are well whilst they are resting in bed, but are unable to take an exertion when they get up, are relieved by using a support for their weak abdominal muscles, so that the diaphragm can be maintained in its normal position.

Under normal conditions the abdominal wall and pelvic floor are the only support of the viscera; the peritoneal folds help to maintain them in position, but they do not support their weight. If as a result of weakness of the muscles of the abdominal wall and of the pelvic floor the viscera drop when the individual is erect, a pull is exerted on the peritoneal folds, which become true suspensory ligaments. Their sensory nerves are constantly stimulated, the patient often complaining of vague abdominal discomfort, which is generally described as a weight or pressure or as being of a dragging nature; it is relieved by lying down and by pressure upon the lower part of the abdomen. The discomfort is most marked in neurasthenic individuals owing to the irritability of their nervous system; if the nervous system is healthy it may be completely absent. It is increased by exercise and physical fatigue, and, to a less extent, by mental fatigue. The chronic pain aggravates the nervous depression, a vicious circle being thus produced, but neurasthenia is never a result of visceroptosis alone.

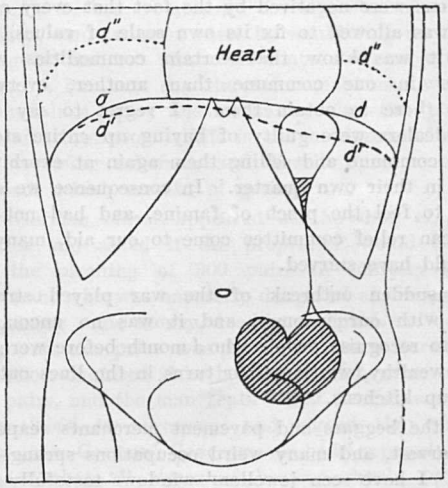
Visceroptosis leads to an alteration in the centre of gravity of the body. In order to maintain the upright position, certain muscles of the spine which are ordinarily little used are brought into action; this is a frequent cause of chronic backache.

The maintenance of the circulation when the erect position is assumed depends to a considerable extent upon the tonic contraction of the abdominal muscles; when this is deficient, as it is in visceroptosis, the abdominal veins dilate and the pulse becomes abnormally accelerated on standing, and giddiness and syncope may also occur.

(To be continued.)



(*a*) Horizontal.



(*b*) Vertical.

FIG. 5. Ptosis of diaphragm in case of general visceroptosis.—Reproductions of tracings drawn orthodiagraphically, showing ptosis of diaphragm, heart, and stomach; the stomach has an "orthostatic hour-glass contraction" in the vertical position. *d*, diaphragm in position of rest; *d'*, diaphragm on maximum inspiration; *d''*, diaphragm when abdomen is compressed; *d*—*d'* in (*a*) = 2½ in.; *d*—*d'* in (*b*) = ¼ in.

Papers by Guy's Men.

Lieut.-Col. A. W. Sheen, M.S., F.R.C.S.: A case of war wound infection by an anthracoid bacillus, the wound being caused by a shattered trigger guard.—*Lancet*, June 19th, 1915.

C. H. Mills, Lieut. R.A.M.C., and another: Severe case of intractable syphilis treated satisfactorily with hectine.—*Ibid.*, June 26th, 1915.

Capt. H. Stott, M.B., I.M.S.: Studies in malaria.—*Ind. Med. Gaz.*, June, 1915.

Some Experiences in Brussels during the War.

BY AN OLD GUY'S MAN.

III.—DURING THE GERMAN OCCUPATION (*continued*).

After the closing of the private ambulances many of us were at a loss for something to occupy our time, our professions and businesses being, for the most part, at a standstill.

Owing to the lack of goods and ready money, many of the shops put up their shutters, notably the small provision dealers, whose stock had either been bought up by their customers or commandeered by the Germans. The communal authorities made some attempt to regulate the prices of foodstuffs, but their good intentions were negatived by the fact that every commune was allowed to fix its own scale of values, and when it was know that certain commodities were cheaper in one commune than another, everyone rushed there to obtain them. I regret to say that many dealers were guilty of buying up entire stocks in one commune and selling them again at exorbitant prices in their own quarter. In consequence we soon began to feel the pinch of famine, and had not the American relief committee come to our aid, many of us would have starved.

The sudden outbreak of the war played strange tricks with our incomes, and it was no uncommon thing to recognise people who a month before were reputed wealthy, waiting their turns in the lines outside the soup kitchens.

But the beggars and pavement merchants reaped a rich harvest, and many weird occupations sprang into being. I have seen jewellers' windows tastefully laid out with boxes of sardines, candles, etc., and nearly every "modiste" had chocolates, cakes, and dairy produce for sale, but at prices which almost equalled those of their legitimate wares. A few enterprising booksellers bought up ancient magazines, and, owing to the literature famine, disposed of them at a handsome profits. Of course, the "illicit" businesses flourished exceedingly. The German Government imposed heavy fines and imprisonment on anyone selling or even found in possession of forbidden newspapers and books, and many were the ingenious devices practised by the vendors. On one occasion, whilst watching a fruit hawker, I was struck by the disparity in the prices of his wares to individual customers. To one he would sell a kilo of apples for 30 centimes; from another he would ask 1 franc 30 centimes for the same quantity. Anxious to satisfy my curiosity I bought a kilo and offered the man 1 franc 30. He made the usual paper "poke" and wrapped the apples in it, but on retiring to a quiet spot to examine my purchase I found that the "poke" consisted of the current number of the forbidden Antwerp newspaper.

After that I became a regular customer, until one day he and his barrow disappeared. So I presume that the Germans had also solved the mystery. The prices of "verboten" newspapers fluctuated according to the vigilance of the German police. Three francs was the usual sum asked for the *Times* or *Daily Mail*, but I have known occasions when 10, 20, and even 50 francs has been asked and paid for a single copy. When prices ruled high it was the custom for several people to club together and buy one copy. The principal items of news were typed out and copies sent to every subscriber. When the news was poor I fancy that the "editor" drew on his imagination so that the subscribers should not be discouraged.

Occasionally the vigilance was relaxed, and copies were plentiful. The explanation of this was that the officers at the Kommandantur had their "literature" carefully regulated from headquarters, and, in consequence they were just as keen on getting outside news as we were.

About this time I had my first intimation of personal danger. The seige of Antwerp had not yet commenced, and up to that period the English residents had remained unmolested. There was, however, a rumour that some young Englishmen had been arrested on suspicion of being connected with the Secret Service. They were closely questioned and released with a warning not to leave the town under pain of immediate execution.

A few days after, when I had returned to my neglected practice, I received warning that I was "wanted" by the German Military Authorities. It had come to their knowledge that someone of my name had been connected with the intelligence department, and, knowing the German habit of shooting first and inquiring into the merits of the case after, I immediately left my house.

For obvious reasons I must not tell you exactly how it was managed, but within a few hours I was in possession of a "certificat d'identite," officially signed and sealed, and bearing my own photograph and description, but not my own name. This paper described me as Mr. X., civil engineer, and an American citizen.

My first act was to destroy all papers and clothing bearing my real name, and I provided myself with note books, projectors, and other impedimenta usually found in the possession of an engineer. Thus armed with my borrowed name and nationality, and an accent to match, I felt comparatively safe. Of course, I could no longer attend to my practice, and I ran considerable risk of recognition by my patients and friends. But my assumed nationality was never once questioned by the Germans, and on more than one occasion I have talked with officers from the Kommandantur.

The Germans are great showmen, but their militarism seems to have spoilt their sense of humour. Consequently they were sometimes very angry when we derided their attempts to impress us. One of their favourite tricks was to march out a large body of troops early in the morning before the town was awake and bring them back about mid-day by another route. At first we were duly impressed and marvelled at the quantity of new troops being brought into the town, but after two or three days of this we began to recognise the faces of the officers and men, and instead of being awed, the populace greeted them with jeers and Flemish familiarities (which outrival our choicest Borough repartee). Some Austrian troops, who had arrived with four pieces of heavy seige artillery, played the same trick. They dragged their huge guns round and round the town until one of them came to grief on the road from Waterloo, and lay ditched for two days.

Since the beginning the Germans had made clumsy attempts to gain the confidence of the populace and so justify the flowery reports published in Berlin of Belgian complaisance. But as Brussels had seen and heard the miserable refugees who crowded into the town from Louvain, Herstal, Dinant, etc., they only succeeded in arousing a sentiment of intense hatred. Failing in this, they tried to foment distrust of England by publishing the text of documents alleged to have been found on English prisoners and tending to prove that England's sole motive in engaging in the war was to annex the Belgian colonies and trade. This also fell flat, and then the amiable Germans attempted to break the spirit of the citizens by extorting money on every possible excuse. They made wholesale arrests on trivial charges, such as obstructing the troops, adversely criticising the German bulletins, and behaving in an insulting manner to the German government. The penalty was usually twenty marks or seven days. If an enemy aeroplane made a successful raid and dropped bombs on their hangars a heavy fine was imposed on the town, "because some citizen must have indicated the positions to the enemy." The Allies usually chose Sunday mornings for these little visits, and we were very grateful to them for the diversion.

On one occasion they successfully bombed the aviation park at X. It was a daring feat of airmanship. Directly the two aeroplanes appeared, flying at a great height, the Germans commenced to pound away with their quick-firers. When over the aeroplane sheds, one of the machines was seen to waver, and commenced to fall like a stone. The Germans cheered wildly and rushed in, thinking they had scored a hit, but when the aeroplane was within 600 yards of the ground it suddenly righted itself and dropped a volley of bombs on the sheds, setting them alight and destroying fourteen "taubes." Then it made off before the astonished Germans could regain their guns. We were fined 25,000 francs for this little exploit, but on this occasion I don't think we grudged it.

One day the Governor complained that a military telephone wire had been cut. Another fine, and the telephone service was suspended. A few weeks after this the Kommandantur announced that for the convenience of the citizens, the telephone might be used on payment of a subscription to the German government. I forget the exact amount, but in any case the citizens did not feel inclined to pay a second subscription for the privilege, and there was no great rush of applicants.

Then the Germans resorted to a most ingenious trick. After weeks of silence the telephone bell would suddenly ring, and a voice would demand if Mr. So-and-so would come to the apparatus to receive an important message. Of course, Mr. So-and-so fell into the trap and rushed to the receiver. The mysterious voice would inquire if it was Mr. So-and-so personally, and on receiving an affirmative the connection was suddenly broken. Naturally the victim's curiosity was aroused, and in most cases he would ring up the exchange to find out what was wanted. There would be no reply, but next day the unfortunate man would be mulcted in a heavy fine for having used the telephone without permission. This is one of dozens of similar money-raising schemes, and I will relate one more incident which smacks of genius.

A German officer appeared at the shop of a dry-cleaner and asked if the proprietor would contract for the cleaning of 300 pairs of military gloves. The man, who was naturally delighted at the prospect of gaining some money, readily accepted the commission, and the price was fixed. As an after-thought the officer inquired if he had sufficient benzine to clean 300 pairs, and the man replied that he had enough to clean 3,000 if necessary, and signed the contract. Now, the German Government had expressly commanded that all stores of benzine should be given up, and they went to collect that dry-cleaner's store next day. They also sent down the gloves and insisted that the contract should be carried out, to fulfil which the man had to purchase his own benzine from the Germans at a huge price.

But the people of Brussels are no fools, and after a time they refused to fall into the most cunningly laid traps. So the Germans were obliged to resort to other methods. They tried to tempt them into open revolt. Belgian prisoners were paraded in the principal streets, the people were ordered to remove the national flag, "as it was likely to cause offence to passing troops," and their liberty was generally interfered with. But they refused to be drawn into any demonstration, and never ceased to hope that the Allies would be there "next week" to drive out their tormentors.

And then one day it seemed that our hopes were about to be realised. The preparations for the seige

of Antwerp were in full swing and the town was full of passing troops and the machinery of battle. All permission to leave Brussels was suspended, and we were forbidden to ride bicycles in the town or environs. This last seemed to be a rather ridiculous order, but the Germans were doing their best to prevent any communication from leaving the town. In spite of all they could do, the arrival and movements of troops in Brussels were accurately reported in Antwerp within an hour.

One Friday afternoon we were startled by the faint sound of cannon. It was really the first time we had heard it in Brussels. It was known that the siege operations were due to commence at any moment, but this sound came from quite a different quarter. By evening the reports had increased in rapidity and volume, and we could plainly distinguish the sound of answering guns.

Next day the town was in a fever of excitement. This was no bombardment, and the sound was coming closer and closer every hour. Surely the Allies were coming at last. The people crowded round the Belliard Statue, in the Montaigne de la Cour, the Colonne du Congres, and at every point of vantage where they could watch the horizon. Occasionally the watchers were rewarded by the far-off puff of smoke from an exploding shell, and by night the sky was patched by the glare of burning villages.

On Sunday the noise had grown to such an extent that we could hardly distinguish the individual explosions. It rose and fell in volume according to the changing wind, sometimes attaining to a crescendo which made every window in the town reverberate.

And all the day through the Porte de Schaerbeek and up the Rue Royale filed a hideous procession of the toll of battle. Every kind of vehicle was represented in that dreadful progress, from huge pantechnicons piled with the battered remnants of human beings to the little country cart driven by a peasant woman and containing the mangled body of some unfortunate villager. I remarked one brown painted motor van bearing the inscription "Bon Marché, Brixton," and wondered how it fell into German hands.

It is possible that the Germans, with their love of theatrical effect, tried to impress us with the horrors of war, or their numbers may have made them careless of the lives of their soldiers, but during those few days we saw sights which sickened us, accustomed as we were to the sights and sounds of the ambulances. The excuse of lack of equipment cannot be urged for the German field ambulances, and it must have been carelessness or callousness which allowed men to be sent off the field of battle without, in many cases, an efficient dressing.

Their favourite method of treating a shrapnel wound in the head or neck was a swabbing of Tinct. Iodi., a pad of gauze or other material, and the man's own shirt dragged up over his head and tied with the sleeves. The blood soaked through everything, and, mixing with the dust, dried by the sun and wind into a hard cake. The bloodier and muddier the shirt the better the dressing held in place. When these human chrysalides arrived at the ambulances they had often to be released from their shells with the aid of the plaster shears, and in many cases the wretched man had been suffocated underneath.

Red tape is the life and soul of the German soldier, but in this case it often proved to be his death. As the ambulances arrived each man was given a number and taken away to the dressing stations, where they were treated in rotation according to their numbers. It was forbidden to take cases out of their turn, no matter how urgent, and if No. 2 was suffering from a shattered thigh and a spouting femoral artery, he must wait until No. 1 had had his cut finger adorned with the regulation quantity of rubber plaster. Small wonder that No. 2 often settled the matter by quitting his existence. This would seem incomprehensible to the English mind, but the explanation given to me by a German medical officer is perfectly logical and characteristically brutal; namely, that a slightly wounded man was of more military value, and consequently better worth their attention, than a potential cripple.

Our hopes of a speedy relief were short lived, and by the following Tuesday the cannonade had died down to a monotonous bombardment, and we realised that our delivery was not yet at hand. It appears that a gallant sortie had been made by the Belgian army from Antwerp with the object of preventing the Germans from placing their siege guns, and although they were unsuccessful in this, I fancy that they gave the Germans a "pasting," which must have reminded them of their first encounter with King Albert's gallant soldiers at Liège.

The hospitals were soon filled to overflowing, and the Germans appropriated the Palais des Academies and turned it into a "kriegslazaret," which was used exclusively for their own wounded. I would have given much to have seen the inside of this building, but is was strictly "verboten" to all foreigners. They also imported civil surgeons from Germany who superseded many of the Belgian doctors who still remained in the ambulances. Although these men never actually illtreated our wounded, they were guilty of one great cruelty. They never gave a limb the benefit of the doubt, that is, if the owner happened to be an enemy. Off it came, and as high up as possible.

They were perfectly frank in their reasons for this very radical treatment. From a medical point of view it simplified the after-treatment and lessened the number of complicated cases in the hospitals. From a military point of view, it rendered the man unfit for any further service. And from an economic point of view, in nine cases out of ten, the man became a

charge on his country. Cold-blooded reasoning, if you like, but the Germans certainly act up to their dictum that war is war, and no sentimental considerations should be allowed to interfere. It is because we have not yet attained the pitch of civilisation which allows human beings to do such things that the Germans sneer at us and tell us that we are only playing at war.

But we "play the game."

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR,—I have had news from France that No. 22 General Hospital is to be staffed, almost entirely, by Guy's men and women. At present there are seven medical officers and twenty nursing sisters there from Guy's. The hospital is out in the country, under canvas, and is equipped for 1,040 beds.

The Matron, Miss Suart, writes, that she would be very glad of some gifts for her storeroom. She specially mentions open backed shirts and long stockings for operation cases, bed jackets, round knitted caps like skull caps, for the head cases, and ordinary shirts and socks. I shall be very pleased to receive and send out any of these or other comforts that friends of Guy's wish to present. Parcels sent to me should be distinctly marked "for France," or they may be sent direct to the Matron, No. 22 General Hospital, British Expeditionary Force.

With many thanks for making this appeal known in the GAZETTE.—Yours faithfully,

Matron's Office, Guy's Hospital, Jnne 28th, 1915.

L. V. HAUGHTON, Matron.

DEAR SIR,—In the course of a pretty busy kind of G. P. practice here, I've had one or two very interesting cases; perhaps the following might do to fill a gap in the GAZETTE some time;—

TWO CASES OF CEREBRO-SPINAL MENINGITIS.

1. A man aged 25, who had never had any illness in his life, after feeling out of sorts for a day, was seized with violent frontal headache, vomited once or twice, and apparently had a rigor. I did not see him until 36 hours later, when he had a pulse of 96, T, 102.4, respiration 26. He was quite sensible, was able to sit up in bed, and answered questions intelligently. There were no physical signs in his chest, and on interrogation he admitted to pain in the back of his neck, though there was absolutely no rigidity. The headache was persistent and very severe.

There was no sign of a rash upon his body, but on examination of his nervous system I found one plantar reflex indefinite, and the other certainly extensor. These were his only signs. However, the meningococcus was cultivated from his spinal canal, and he did very well under treatment with serum in the Isolation Hospital here (the American serum is now used exclusively).

2. After this I had all contacts swabbed, but with no result.

About 10 days later a sergeant from the same block, but not the same room, one of the finest built men I have ever seen, came to me complaining of a sore throat and feeling out of sorts.

There was very little to see in his throat except a dry pharynx, and on examining him carefully I found signs of consolidation at one apex. I therefore sent for his Medical History sheet, and found that he had before been suspected of phthisis at the apex, though no tubercle bacilli had been found. He owned to a cough, so I collected some sputum and had it examined with negative result and then let the matter drop. However, a fortnight later this man was seized with sudden headache, nausea, and pain in the back of the neck; he also had a certain amount of rigidity, *i.e.*, he could not touch his chest with his chin: Kernig's sign was positive. I sent him to the Isolation Hospital where he was diagnosed as a case of cerebro-spinal meningitis, though this was never proved by lumbar puncture. The authorities there state that they have so many cases of this mild type that they are content with a diagnosis on the physical signs without the penny in the slot climax. The man did well with rest and was about in three weeks.

This was interesting if really a case of cerebro-spinal, for the prodromal symptoms. He was one of the dozen or so bad colds who come up every day, and the only symptom which drew my attention to him at all was the obvious fact of his feeling weak and depressed to a degree most abnormal in a keen N.C.O.

A CASE OF POISONING BY TETRACHLORETHANE.

3.—The patient, a fine healthy girl of 21, was first employed in the factory three months ago, where she worked with many other girls in a large shed in which the planes are painted with "dope," a varnish containing various constituents with tetra chlorethane as the main solvent. She had never had any illness before, but soon after commencing her work in the shops began to complain of headaches, loss of appetite and lassitude, though these symptoms were never severe enough to prevent her going to work.

Then one Monday a fortnight ago, for the first time, she complained of abdominal pain, and it was noticed by her friends that she was yellow about the eyes. On the Friday she went to bed and was attended by her doctor thereafter; apparently the pain disappeared, but the jaundice increased, and when I first saw her ten days later it was very deep. She was then in a semi-conscious state, varying between periods of drowsiness and cerebral irritation. She was taking hardly any food, and vomited several times, once bringing up some blood.

Her tongue and breath were very foul and her bowels were only open with strong purges.

Temperature normal: pulse 98. The general colour of her skin was more olive than lemon yellow.

On examination, her nervous system appeared normal: nothing in circulatory or respiratory systems; bile in urine; no albumen. The area of liver dulness was, however, markedly decreased.

On the following day she was in much the same condition mentally: vomiting had ceased, but she was still taking no food, and the pulse was 120 and small.

The next day she was absolutely comatose, breathing stertorously, and a purpuric rash had appeared on her neck and chest; she bad a very feeble pulse, and finally died early on the following morning.

Post-mortem.—The fact of greatest interest was the size of the liver; this weighed only seventeen ounces and was normal in shape, but shrunken in size, so that the left lobe reached very little across the mid line, and the lower edge was right up under the ribs. In substance it almost exactly resembled the liver seen at the post-mortem on the case of acute yellow atrophy at the Hospital a year ago, except that the small amount of liver tissue which remained was not maroon in colour, but darker and bile-stained.

Most of the right lobe was taken up by a large canary yellow mass the size of a cricket ball, and the rest of the organ was mottled with small patches of a similar colour.

On section this mass appeared to the naked eye to consist of a fine network of fibrous tissue containing bile stained fat. The heart muscle was very soft and flabby, and there were numerous hæmorrhages under the pericardium. The remaining viscera were normal on naked eye appearance.

The whole case so exactly resembled the series described in the *Lancet* last Christmas as having occurred at Hendon, that there appeared no doubt about the diagnosis.

Royal Flying Oorps, C. P. SYMONDS.
S. Farnborough,
Hants.
23rd June, 1915.

No. 22 General Hospital, British Expeditionary Force, France.

All past and present Guy's men and women will hear with pleasure and pride that the above Hospital is to be staffed with Guy's trained women entirely, if possible, otherwise to a large extent. On the Medical Staff we are informed that seven Guy's men are appointed, so we shall hope to hear from them of their side of the work. The following letter received at the Guy's Trained Nurses' Institution, June 26th, brought the welcome news.

"Dear Sister,—Writing to let you know that I am now attached to No. 22. We are now 4½ miles from (Censored) and 2 miles from the sea. This is a very small village, one tiny street and two or three minute shops. Miss McCarthy has decided this is to be a Guy's Camp out of compliment to all Miss Haughton has done in advising so many nurses to join the Civil Hospitals Reserve for the present war, and her work on the Nursing Board at the War Office. Miss Suart, Q.A.I.M.N.S.R., who holds two South African War Medals and left Guy's in 1900, is Matron. Miss B. H. Daniels (late Sister Ruth) is Assistant Matron. To date the staff consists of Misses V. Kiddle, E. Fraser, E. H. Shackleton, M. Beardshaw, M. A. Hilliard, L. Cornwall, F. Hepburne, M. Bourdillon, M. Nelson, W. A. Warner, K. McKensie, D. Grundy, D. King, V. Strutt, S. E. Surtes, H. Banbury, F. L. Davies, A. M. Phillips. Will let you know who else is appointed."

We shall hope to hear frequently from No. 22 General, and would suggest a Gazette supplement. The censored words would supply an interesting competition. We are sure that the best wishes of all readers of the Gazette at home will go forth to our representatives abroad.

If the Guy's motto cannot be emblazoned on canvas walls in work achieved may all find set forth, "Dare Quam Accipere."

Nursing News.

Matron's Office,
29th June, 1915.

From the long lists in the papers we congratulate the Guy's women honoured.

Mentioned in Despatches.

Sister.—Miss G. M. Allen, Q.A.I.M.N.S., Guy's, 1898 to 1902.

Acting Sister.—Miss M. C. Corbishley, Q.A.I.M.N.S., Guy's, 1906 to 1909.

Miss V. Kiddle, Civil Hospitals Reserve, Guy's, 1906 to 1914.

Awarded Royal Red Cross.

Miss M. Corbishley. Miss V. Kiddle.

Miss Evelyn Windemer, Sister Bright, 1906 to 1910, is now working as Night Sister at the Fishmongers' Hall Hospital for Officers, London Bridge.

Miss E. Canter, who was at Colchester Military Hospital since October, 1914, has now been appointed to the H.S. "Asturias," and is expecting to go to Malta. Until now the "Asturias" has carried wounded between France and Southampton.

To Matron, from Miss Eagle.

Paris,
May 2nd, 1915.

"I have been wanting to write to you for a long time. I left Arc en Barrois 3 weeks ago, with many regrets; I just loved the work. These French soldiers are such nice men to nurse; they are grateful, and respond so quickly to good treatment. Their wounds were fairly bad, but, of course, the cold weather was much

in their favour; often they had been two or three days in the trenches or trains after their first dressing. I used to get many bad wounds in my ward; it was the largest and most sunny room in the chateau.

"Poor fellows, they are so brave! One cannot work long among these French people these days without being struck by the courage of both the women and men. And oh, how they suffer! One sees and feels it everywhere; all have lost or have people in the war.

"Paris is waking now; though she is still a very subdued city. A few of the places of interest are opening, but her treasures are still in safe keeping. The great spirit in the air is to fight through at all costs. And at what cost to us all only those realise fully who are working amongst it all. One shudders when one thinks of the mass of suffering there will be for years to come. One's mind reels at the diabolical things men will do: war to-day is worse than hell. We Allies have long odds to fight against, but we *must* win.

"Now I must tell you about the hospital. It is a beautiful chateau, standing in a lovely park, with the river winding through; in the distance are woods on gently rising slopes, which in the spring are simply exquisite. The clouds and atmosphere, too, are beautiful and the air very clear and good; there are many beautiful flowers in the woods and park, and sometimes one sees a deer. The chateau is a hunting box belonging to the Orleans' family, but rarely used, perhaps ten days in the year, the hunting consisting of wild boar, with plenty of trout fishing in the river.

"The house is large, with many large rooms opening French fashion into each other, making them very convenient for wards. The two largest wards are the Salon, with 16 beds, and the Dining Hall, with 16 beds also. All the ducal furniture has been cleared out of the place, except in the rooms used by the staff. There are 108 beds in the hospital, but many are empty now; it is getting rather far back for badly wounded cases. The operating theatre is the princesses' boudoir, though it does not much resemble one now, for it is quite well equipped for its use.

"I had the Salon for my ward, named after General Gallieni. It is a beautiful, long, wide room, with light oak panel and ceiling and polished wood floor. It has a large open fireplace with a finely-proportioned stone chimneypiece, and 3 long windows opening on to the park and distant view. It has full south aspect, so was ideal for septic cases, though I am afraid it will be too hot for the summer. The whole place had to be lighted with oil lamps. We were most fortunate in having a cold water tap on each corridor. It was a fair distance from some of the wards, but it was better than none. The drinking water was fetched from one source in the kitchen. The hot water question was met by having a small French stove in each of the big wards and one between two or three wards which opened into each other. On these we kept a big zinc pot always full; they were a great bother to the V.A.D., but most successful otherwise.

"The sanitary arrangements were quite primitive, all refuse being buried in cess pits. The sanitary arrangements in the house were in plenty, but the drains not in a safe conditions for the use of so many people. Of course, it made much work.

"I can't say how I hated giving up my ward; it was like parting with a child. It was absorbing to see the thing growing under one's hands.

"When the first batch of wounded arrived there were only the beds and one small table in it, and very few utensils for dressing, etc. And oh, those French beds! They consist of a palliasse stuffed with straw and soft wool mattress. It was impossible to keep a fracture in place on them; the straw sinks where the patient lies most, and finally you find him half on the floor. We had a gentleman orderly (nephew of Judge Phillimore) who was extremely clever at contriving and making things. We talked the matter over, and he made fracture boards about a foot high for the worst leg cases, and on these we put the mattress and did away with the palliasse. They were most successful, and so nice to carry the patients outside (we always put all the patients outside whenever possible—on their mattress or stretchers. They loved it so much, and it did them such a lot of good; we often exposed very dirty wounds to the sun). The remaining palliasses I stuffed more straw into so that they could not sink, and for ever after had tidy beds. When I left, the ward had two long tables, a small table between each two beds, for meals, etc., and chairs for nearly all beds—all made by the orderlies and members of the staff. How everyone worked! I had only to ask for and suggest something, even crutches, etc., and behold! in one or two days they would be in the ward.

"I met many interesting people at Arc—among the staff and doctors, artists, etc., M. de Ghlen, the portrait painter and his wife, who is also an artist, orderlies, Mr. Tonks and Dr. Dakin, doctors who have forsaken their professions for art, Mr. Masefield, the poet-orderly, and whom one feels better for having seen at work, Susan Storey, the American Singer, who was at the head of the patients' kitchen—she was a most excellent manager and a personality, Miss Tomlinson, also a singer and in the kitchen, and amongst our V.A.D.'s we had Lady Betty Kepple. On the whole, the V.A.D.'s were very nice girls and very helpful. So, you see, we had rather an electrical company.

"Sister Gibson was night superintendent.

"I have the Guy's GAZETTE sent to me regularly; it is always good to know what the dear old place is doing. I am hoping to pay a visit to Versailles this week. So far, I have met very few Guyites; you must feel the loss of all the people who are in France and elsewhere. I am glad to read of Sister Kate's engagement; also to see the names of Mr. Carey and Dennis Brown among Guy's on active service.

To Matron, from Miss Beardshaw:—

24th June, 1915.

"It is a very long time since I last wrote, but once I had told you of our train life there was nothing but everyday details which made one day different from another. I am very glad to have had the experience of train life and to have had the opportunity of seeing everything from the Clearing Stations to the various bases, and to see how things have developed from January to June. Still, four and a half months was quite long enough, and I was ever so glad to be sent to No. 22 General, and then to discover that it was all Guy's.

"I expect you will get many letters from the colony, and I can't attempt to give you any account of it, for it is by no means in working order yet. Fortunately there are only two patients as yet in the

1,040 beds (which are reported ready!), one a surgical case, accident on the line close by, and the other a medical case, who is 'just weary!' But for wards at present one sister and one staff nurse are appointed to three rows of three tents, each tent containing 13 beds, *i.e.*, 117 beds.

"All there was to begin with was tent, bed, and bedclothes; so, you see, we are working up again from the very bottom as we did at No. 4 in September. The authorities give you so much—quite insufficient, and the rest has to be drawn by each individual sister. So that you feel as if you were asking favours when you put in for essentials which are not issued at the beginning.

"The Canadians bring over their equipment complete, and why can't we? It would save so much muddle. Ever so many of the most ordinary things have had to be sent for. What we should do if England wasn't safe and sound, just across the way, and supplying us with everything we choose to ask for, I do not know. It is simply splendid.

"We are all so looking forward to a visit from you, and we must have things quite in order and truly Guy-like for you to approve. The scene would fascinate you (there is much that we may not talk about, censorship being strict). We are pitched at the usual place, 'somewhere in France,' and it is far away from civilisation, at least, it seems so when you want anything: the nearest shop within four miles is the 'canteen.' To the back of us is a line of hills, which are a source of great joy (in spite of wretched advertisements cut in the turf), sometimes covered with mist, sometimes blazing in the sun, as they are this afternoon. Then, across the railway which runs past our camp are two miles of sand dunes, dotted here and there with clumps of fir trees between us and the sea. Earwigs (chiefly) and other insects are among our minor trials here; they seem to appreciate sponges and any article of clothing which hangs up in the tent, but they are very minor. The soil we are on is chalk and sand, so we ought to keep fairly dry.

"Those of us who came out in August last have been asked to sign on for another year. I have done so, for, really, one felt one could not do otherwise. The whole war is so horrible that one must simply be content to do one's own horrid bit up to the end; it will be good to be at that end, though. At times one simply longs to be home, but I really believe it must be harder to keep on there than it is out here.

"We are having ten days' leave, and I hope to get mine in August, and am looking forward to seeing you then, if we do not see you here before.

"There is much more that would interest you, could one write freely, but it will keep and improve—till you come."

Change of Address.

Surgeon H. L. Peregrine, H.M. Hospital Ship *China*, c/o G.P.O., London.

Dr. H. E. Vincent, Restcot, Russell Crescent, Horley, Surrey.

M. A. Hilliard, No. 22, General Hospital, British Expeditionary Force, France.

Reviews, etc.

A Practical Handbook of Surgical After-Treatment. By Alan H. Todd. (Edward Arnold.) 4s. 6d. net.

We have read this book with great pleasure, and heartily congratulate the author upon it. He has given us an eminently practical and sound book, based upon his own experiences, and for the most part has omitted all theoretical considerations except where some mention of them seemed essential to the proper understanding of the treatment recommended.

The first two chapters on preparation for operation and treatment after operation are excellent, and contain a large number of valuable hints. The treatment of hæmorrhage is first taken as a whole, and then the methods of meeting it after particular operations. Shock is admirably and briefly described and its treatment dealt with. The chapters on wound treatment, bandaging, and strapping are helpful. The next few chapters contain valuable advice for the after-treatment of each of the more common operations. Finally there are chapters on the use of catheters, treatment of inflamed and non-inflamed joints, eye operations, the after-treatment of operations and injuries of the limbs, massage, plaster splints, local analgesia, and directions for measurements of a Thomas' splint.

We recommend this book most heartily to House-Surgeons, and with its help they should be able to cope with the many difficulties that arise, when they first have the responsibility of after-treatment. It is too little the habit to read books on this very important subject, and, as a rule, the house-surgeon only gradually learns it at the expense of his patients' feelings.

The learning of after-treatment should be acquired during the time when a man is acting as ward clerk and dresser, so that he may have a sound working knowledge when he has the responsibility of the after-treatment. We, therefore, urge dressers and ward clerks to read this book, which is so vigorously and clearly written.

Sisters and nurses, on whom falls the bulk of the carrying out of the details of the after-treatment, will find Mr. Todd's book a great help, especially in the clear explanations given for each treatment.

Births.

MARSH.—On June 22nd, at 1, Cantelupe Road, Bexhill-on-Sea, to Mr. and Mrs. H. E. Marsh, a son.

WATSON.—On June 20th, at Lancaster Place, N.W., the wife of Major D. P. Watson, R.A.M.C., of a daughter.

Marriage.

ROOK—CALWAY.—On June 12th, at St. George's Church, Wilton, Taunton, Henry Colwell Rook, Lieut. R.A.M.C. (S.R.), to Alice Marguerite, elder daughter of Mr. and Mrs. F. Calway, of Henley Lodge, Taunton.

Death.

BODKIN.—On June 23rd, at Trevelyan House, Tiptree, Essex, Arthur Malcolm Bodkin, M.B., B.C., Cantab., only son of A. A. Bodkin, Esq., Oxford, aged 30 years.

E. M. G.

GUY'S HOSPITAL GAZETTE.

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Passim.

UNDOUBTEDLY the time at which a medical man shows the greatest keenness for his profession is when he is newly qualified.

At the beginning of the war the choice of a career in the immediate future by a man in such a position lay in three channels, namely, in holding House Appointments, or in entering the Army or Navy Medical Services.

To-day, this has undergone considerable change. Whilst House Appointments are still the first to be considered by men who are in a position to continue their work up at the Hospital, yet the question of entering either of the Services is not entertained so keenly as it was in October last.

The reason for this is not far to seek, and it is found in the general opinion expressed by those Temporary Surgeons who were enrolled during the first few months of the war.

A few of those who joined the Royal Army Medical Corps became attached to regiments, and have used their medical knowledge on active service with results which we all know so well, but the greater number have remained in England for many months. During this time they may not have treated a single case, and their sole duty has lain in instructing R.A.M.C. orderlies in stretcher drill and elementary first aid. Whilst not attempting to deny that such training is necessary, we can well imagine the feelings which prompt the expression of gloomy opinions by Temporary Surgeons in the Army.

Speaking from a medical point of view, the fate of men who joined the Navy is, perhaps, better. They have been sent, in most cases, first of all to a Naval Base Hospital, where they have been put in charge of wards, and then, in some cases, they have been appointed Medical Officers to armed liners or some of the smaller ships of the fighting line.

Can we be surprised, then, to see recently qualified men deciding to apply for posts as House-Surgeons or House-Physicians to hospitals in England where they have a wide scope for employing their originality and knowledge?

Unfortunately the matter does not rest here. The authorities still appeal for more doctors, and official appeals are not in the form of rhetorical questions; they demand an answer.

Again, it is the opinion of many that Military Hospitals at home can be run by older men who are in general practice or holding civil appointments in England. We certainly believe this to be true in part, but to what extent we are not in a position to say. We are, however, firmly convinced that there are medical men in England who, having ties which perforce keep them at home, are in a position to perform duties in home hospitals, and by doing so to release the younger men for active service in the R.A.M.C.

Without a doubt it is a great sacrifice, having worked hard to get qualified, to give up the

medical profession for a few months before being transferred to the fighting line where our knowledge is indispensable, but it is one which must be made regularly by medical men. For, as our fighting forces increase in number, so must there be doctors to go out with them. Not only that, there must be a reserve from which men may be taken to replace, maybe our friends, or, at any rate, our colleagues in the profession who have met their death in serving their country.

In this short article we have not attempted to thrash out this question, but invite our correspondents to make use of our columns to that end.

MANY old Guy's men will have noticed with regret the death of their old teacher, Mr. Clement Lucas, Consulting Surgeon to the Hospital. His career and the untiring energy with which he interested himself in students will be found in another column.

SINCE our last issue we regret to have to publish that Lieut. W. R. Pryn, R.A.M.C., has died in France as the result of burns. He left the Hospital so recently that he will be remembered by most people connected with Guy's at the present day, and on behalf of them we would like to offer our sincere sympathy to all his relations and friends.

MR. SHENTON very kindly invited us to the Surgical X-ray Room last week in order to explain his new system of recording all the interesting results obtained in the Department.

Always, heretofore, it has been the custom to store all the plates which were taken of cases sent to be X-rayed. The difficulties attached to this were manifold, and reference to old cases has given a lot of trouble.

Under the present system, if an interesting plate is taken, the surgeon merely attaches a special ticket to it, and then three prints are taken. One is sent to the surgeon, another is put into a library of X-ray prints arranged in numerical order, whilst the third is kept for future classification.

Thus, there is one class for calculi, another for foreign bodies, another for fractures taken as a whole, both before and after treatment, and so on.

Mr. Shenton has very kindly put all these records at the disposal of anyone who would like to make use of them for compiling lectures or for any other purpose. We feel confident that this offer will be accepted by many.

THIS week we publish the Annual Report of the Clubs' Union for 1914—1915, the Revenue Account for the year ended March 31st, and also the constitution of the Council for the current year.

The Clubs' Union have decided this year not to publish a Year-Book, as information regarding the various constituent institutions is difficult to obtain and the addresses of Members of the Union are continually changing on account of the war, so that it would be impossible to compile a Year-Book accurately.

WE are publishing also two photographs of Guy's men who have fallen in the war, namely, Lieutenant Pern and 2nd Lieutenant Waghorn. Knowing how these will be valued by all Guy's men who knew them, we hope to publish similar copies of photographs of all men contained in our Roll of Honour.

Arrangements have been made to send all copies of the GAZETTE containing these prints in envelopes so that they will not be injured, which would be the case if they were sent folded, which is the usual way of transmitting the GAZETTE.

HEARD AT THE FRONT LODGE—

Female Visitor. I want to see Mr. ——, please.

Porter. Yes; what ward is he in?

Female Visitor. The Haccident ward I think they told me.

Porter (after 'phoning Cornelius and Astley Cooper). Are you any relation of Mr. ——?

Female Visitor. Why, of course! I'm his landlady.

Lieut. MONTAGUE PERN

(R.A.M.C.),

Killed in action on May 9th, 1915.

Educated at Marlborough and Guy's Hospital. M.R.C.S., L.R.C.P.

2nd Lieut. L. P. WAGHORN,

Killed in action while serving with the Berkshire Regiment.

Educated at Marlborough and Guy's Hospital.

OUT-PATIENT LETTER.—Please nurse will you push my child forward bcos I cannot com myself bcos he has been complaing of thraut chest and back when breathing his age is 8 next birthday you will oblige me. Mrs. H—.

Obituary.

RICHARD CLEMENT LUCAS,
M.B., B.S.LOND., F.R.C.S.

CONSULTING SURGEON, GUY'S HOSPITAL AND EVELINA HOSPITAL FOR SICK CHILDREN.

BY the death of Richard Clement Lucas the profession has lost an eniment surgeon and a remarkable man. His was a distinct personality which cannot be ignored when the surgery of the late Victorian era is under review, and his name will be always associated with the early development of renal surgery, a subject in which he took a continued interest. The son of the late Mr. William Lucas of Oaklands, Midhurst, Sussex, he was born on April 16th 1846. and was thus in his 70th year. Educated at Queenwood College, Stockbridge, Hants, he afterwards entered as a student at Guy's Hospital in 1863, and had a distinguished academic career at the University of London, taking the M.B, gold medal in 1871. He qualified as M.R.C.S. and L.R.C.P. in 1868, and became a Fellow of the College of Surgeons in 1871.

Lucas served Guy's Hospital for nearly half a century, distinguishing himself in all the appointments which he held. In 1872 he became assistant demonstrator of anatomy, the senior demonstratorship being awarded to him in 1874. In 1877 he was made demonstrator of practical surgery. In 1875, while he was holding these appointments in the medical school, he was elected assistant surgeon to the hospital, and thirteen years later, in 1888, he attained the rank of surgeon, retiring in 1906. From 1888 to 1900 he was lecturer on anatomy and in later years he became lecturer on surgery to the hospital, holding the latter lectureship from 1900 till his retirement. Lucas devoted an enormous amount of time and energy not only to his hospital duties but also to the education of the students, in every one of whom he took a great personal interest. Quite a number of his colleagues owe their success in life to the stimulus which he applied to them by his interest and advice in the early stages of their careers. He used to ask the first year's men to meet him in order that he might discuss with them collectively and individually the best course for each to pursue in his work, and few who were present at one of those talks will forget the strong impression that he made upon the young student. Full of ambition himself, and indefatigable in work, he certainly possessed a wonderful power af inducing energy in others.

In his prime he was a masterly operator, bold, rapid, and certain. Nothing pleased him more than a deep and extensive dissection in the neck, in which his dexterity and anatomical knowledge had full play. In his work he was always teaching the student, and the interest of his lectures was notably enhanced by the excellent lightning sketches with which he illustrated them.

Lucas wrote a large number of papers on anatomical and surgical subjects, in many of which he displayed remarkable originality. Needless to say, a man of this calibre does not go through life without encountering much opposition. An interesting example of this is worth recording because of its surgical interest. Early in 1880, when the relations between the governors and staff of Guy's Hospital were at a considerable tension, Lucas, then an assistant surgeon, had as a patient a man who was very ill with a tuberculous kidney and a discharging sinus in the loin. Lucas proposed to remove the kidney —an operation which at that time had rarely been attempted, and never, so far as we know, successfully. The governors refused to sanction the operation, but Lucas denied their right to interfere between his patient and himself, and in the presence of the superintendent, whom the governors had deputed to represent them, he operated with a most successful result, as the patient was shown more than twenty years afterwards.

Among the students as a whole Lucas was always to the fore as a patron of sport. For many years he was president of the Students' Athletic Club, and he founded the "tug-of-war," which became such a popular institution at Guy's. His love of sport also made him a prominent figure in the hunting field, where he was a well-known follower of Lord Leconfield's hounds, rarely missing a Saturday meet.

In 1901 Clement Lucas was elected a member of Council of the Royal College of Surgeons, retaining his seat till 1914. He was vice-president of the College from 1909 to 1911, and, in the latter year, Bradshaw Lecturer.

Mr. Lucas married Miss Kathleen Emma Pelly, daughter of Surgeon-General Saville Marriott Pelly, C.B. There were two sons of the marriage, one of whom is now serving as a second lieutenant in the Royal Field Artillery. W. A. L.

WILLIAM DENIS BROWNE,
Killed in action June 7th, 1915.

Denis Browne came to Guy's in January, 1913, and succeeded Clive Carey as organist to the hospital and conductor of the musical society.

He was educated at Rugby school and Clare College, Cambridge, where he held a classical and two musical scholarships, and was already marked as a musician of exceptional promise.

His compositions included a short ballet and a few admirable songs, and some Latin church music which has been performed at Westminster Cathedral.

He joined the Royal Naval Division last September with his friend Rupert Brooke, and took part in the Antwerp Expedition. He was slightly wounded at the

Dardanelles on May 8th, and had only just rejoined his battalion when he was killed.

His singular charm of character had gained him many friends, and he will be long remembered by all who met him at Guy's.

"D.B." was one of the fortunate few who possessed an artistic temperament together with an absolute lack of snobbishness; his sincerity could never be doubted for an instant by any one with whom he came in contact. His friendship was a thing to be prized, and though he was only at Guy's for so short a time, there are many here who will feel that "The world is poorer for a man."

EUSTACE FERNANDO LLARENA.

Killed in action.

"Larry," as he was known to all his old friends up at the Hospital, received his early education at Dulwich College, where he was an enthusiastic "Rugger" player and a Sergeant in the Officers' Training Corps.

He entered the Medical and Dental Schools in October, 1910, and passed his first professional and First Conjoint Examinations in 1912.

When the War began he was working for his Second Conjoint Examination, and he joined the Artists' Rifles last August. He obtained his commission while in France and became Second Lieutenant in the the 2nd Battalion of the Suffolk Regiment.

One of his Hospital friends writing from France says: "He was killed by a shell on the fourth and last day of an attack on a wood near Ypres, while clearing the last corner with his machine guns. He was extremely popular with officers and men alike. Of a cheerful and happy disposition, he was a man in every sense of the word."

Always to the fore in any sport, he gained his "Rugger Blue" in the 1912–1913 season, and played for the 1st XV. regularly afterwards.

As a water-polo player he also excelled and was a member of the water-polo team in 1911 and onwards, and in 1914 captained the team which wrested the cup again from the London Hospital. He also figured as member of the Inter-Hospital Swimming Four.

By the death of E. F. Llarena the hospital has lost one of her best athletes who answered the call to arms during the first week of war, and now must be added to the Roll of Honour of Guy's men, who have met that glorious end on the battlefield.

Notice.

Massage Department.

In view of the considerable enlargement of the Department lately effected, and of the employment of 16 pupils exclusively on massage and remedial exercises, the Staff are informed that it has become practicable to carry out treatment for a much greater number of cases than heretofore, and that wherever massage may appear to be indicated, it may now be freely ordered without the fear of unduly taxing the strength of the Nursing Staff.

E. C. PERRY, Superintendent.

July 2nd, 1915.

Nursing News.

MATRON'S OFFICE,
13th July, 1915.

Last week Miss Beesley, Guy's 1909, who has held various Sister's Posts and the Matronship of High Wycombe Cottage Hospital, Miss Sadler and Miss Hayne (who have just completed their training) left for France as Civil Hospitals Reserve.

Leave is now being granted, 10 days inclusive, and it has been a great pleasure to welcome Misses Jolley, Banbury, Wilson, Finnis, Spedding, Ames, Mann, Hickman, Robinson and Brown.

Many will have compiled a year's service in August, and in rotation the War Office is requesting a renewal of their engagement.

Miss Jolley has joined No. 1 General, and on their return to France, Misses Spedding, Mann, Hickman and Wilson have orders to proceed to No. 22 (our special Hospital).

From the Matron, No. 22 General Hospital.

No. 22 General Hospital,
Army Post Office, S 11,
B. E. Force,
25th June, 1915.

Dear Miss Haughton,

Thank you for your good wishes that Guy's Hospital in France may be a success. I do indeed hope that it may be so. There are twenty of us here at present, but I have not half of my staff yet. I feel it is rather a responsibility! Miss Daniels is helping me. Enclosed is a list of the people who are here, all strangers to me of course, with the exception of Major Turner.

It is very kind of you to offer to send us some things. My store room at No. 8 was well equipped, but here we have absolutely nothing in the way of comforts for the patients, so that anything useful for them will be very acceptable. I think it would give very great pleasure to everybody if in the future you could come and see us. We are ready to receive patients now if necessary, but there is still much to be done. With kind regards.

Yours sincerely,
H. SUART.

From Miss Gibson (now in England), Guy's Institution,
June 17th, 1915.

"How about Arc en Barrois, our tiny hospital with only 104 beds. When I read about the larger hospitals, and also hear about them, I cannot imagine that anyone will think much of any thing I can write. Arc en Barrois is a small village, about 14 miles from Chaumont, and Duc de Penthièvre, lent his Chateâu as a temporary hospital for the French wounded.

"After a very cold journey, I, with eleven other nurses, arrived there on the 2nd of January. I remember so well how the faithful caretaker and his wife were loth to take us in, and how impossible it seemed to them that it could be right for us to clear certain rooms of furniture, etc.; indeed, if the Germans had invaded the house, they could not have worn a more dejected look than they did on the first Sunday night, when we sang hymns, and at the same time made use of the piano, which had not been played for 10 years. For three weeks we were busy getting ready, the French Military sent us a hundred beds—to each bed a mattress, a palliasse and a bolster, and five sheets. The palliasses had to be made at the Château. A few loads of straw were deposited in the entrance hall, and the women from the village came, and in a very few days each bed was finished. For counterpanes we had brown rugs, also 100 pairs of very good blankets. For screen covers we had pale blue casement cloth, sent out from Selfridge's.

"The orderlies made long narrow tables for the wards, also small tables to stand by the bedside of the patients. They also made fracture boards and planed small boards which were very useful as trays. We had a stove put in each ward, and on this we heated our water in large urns. Dressings were done soon after 9 a.m., and afterwards (weather permitting) the patients were allowed to go out in the park. Those who could not walk were carried out on stretchers, and often the whole bedstead had to be taken, in cases of fractures; the patients always enjoyed the open air and looked better for being out.

"The day Nurses were called at 5.45 a.m., breakfast at 6.30, on duty 7. They gave the patients breakfast and made beds, and got wards tidy, etc., by 9 o'clock for dressings. They came off duty at 8 p.m. Two hours off duty daily if convenient. The night nurses all slept out at various houses in the village, they breakfasted at 7.30 p.m., and were on duty at 8 p.m. Patients were awakened at 6 a.m. for ablutions. Of course if a patient slept badly he was washed earlier, and would then often have his best sleep, sleeping right on until breakfast time. The night nurses came off duty at 8 a.m. and had dinner, and were allowed to stay up until noon or to retire at once and get up at 5 p.m. We usually had our 'take-in' at night.

"The ambulances started off at 10.30 p.m., orderlies and one doctor and one or two others usually went to La Trecey station, seven miles away. In the winter time we sent soup and one hot water bottle for each patient. The ambulances usually returned soon after midnight. The other two doctors and two dressers (ladies), and all the lay people always got up or stayed up for 'take-in.' They were exciting nights. Lights turned fully on (oil lamps), the patients *would* wake up and always enjoyed (apparently) this interlude in their beauty sleep. The patients were put into bed on receiving blankets and covered up, great care being taken of their clothes not to get them mixed or mislaid. Each one had a ticket tied on to a button on his coat denoting the nature of his wound and other particulars. A hot drink was given as soon as convenient, and his clothes removed so that the dressing could be examined by the doctor who made a round of the new patients as soon as they were all in bed.

"If the dressing was not through much, and the patient was not in great pain, it was left until the morning. After the doctor and the others had retired, a hot drink was given to the old patients, often a nice cup of tea (for we found that even the French loved tea), and soon they were off to sleep again, except, of course, the very ill ones. A list was made of each patient's clothes and they were put into a sack, tied up, and put outside the ward door until the morning, when they were taken to be fumigated. If the patients were tired, they were allowed to sleep, but the night nurses usually succeeded in getting them washed and made comfortable before the day nurses came on duty.

"We took in from 10 to 25 patients at a time. One night we were told that 17 were coming, but 25 came, so we had to put up bedsteads quickly, even the Matron helped to carry the mattresses from the top floor to the ground floor. Some of the wounds were just horrible to look at, and it was marvellous how they mended, but some went on suppurating for a long time, and not a few had severe secondary hæmorrhage. A small wound near a joint, sometimes necessitated amputation later. The chief lotions used were Hydrogen Peroxide—Carbolic—Iodine and Hydr. Perchlor; Boric Acid fomentations were used with success for cleaning wounds. Many patients had continuous irrigation to their wounds.

"There is a beautiful and well equipped theatre. The sanitary accommodation, which was arranged by Dr. Dakin (late Guy's) and the orderlies, has proved efficient. Not any of the lavatories were used for ward purposes, in case of typhoid. We soon found that a mortuary would be necessary, and one little turret-room was set apart for that purpose. A little altar was given and it looks quite nice. The mourners are allowed to sit with their dead loved ones before they are taken away to the cemetery. All the village people go to the funerals and all subscribe for a wreath when a patient dies. The soldiers' graves (15) are beautifully kept.

"The Hospice has been turned into a Convalescent Home and is usually full (70 patients). From there they go to the Military Depôt, usually 10 every Sunday—then the following Monday the Hospital sends on another 10. Many of our patients went back to the front, others will never be fit for active service again. As patients they are ideal, and I am glad to have had the opportunity of doing a little for some of them. It was with a sad heart that I said adieu to them last week, especially those who have suffered much, and who have yet much to endure before they are well.

BOOKS, ETC., RECEIVED.—The Prescriber, The Polyclinic, The Nursing Times, The Hospital, St. Bartholomew's Hospital Journal, The Middlesex Hospital Journal, St. Mary's Hospital Gazette, and The Magazine of the London (Royal Free Hospital) School of Medicine for Women.

Guy's Hospital Clubs' Union.

Annual Report, 1914—15.

THE Council of the Clubs' Union begs to present the Twenty-third Annual Report of the progress of the Union, together with a Statement of Receipts and Expenditure for the year ending March 31st, 1915.

The total membership of the Union now stands at 2,992, of whom 2,640 are life members, 315 annual subscribers, 27 patrons; and 10 honorary members; 105 new members joined the Union last year.

The balance of the income over the expenditure for the year was £170 15s. 9d., as compared with £175 2s. 3d. in the previous year.

R. P. ROWLANDS,
Chairman.

REVENUE ACCOUNT FOR THE YEAR ENDED 31ST MARCH, 1915.

Expenditure.

	£ s. d.	£ s. d.
To Grants to Constituent Institutions—		
Cricket Club	32 13 2	
Debating Society	5 0 0	
Dental Society	10 10 0	
Guy's Hospital Gazette ..	103 5 0	
Lawn Tennis Club	7 0 0	
Students' Club	134 10 11	
Hockey Club	15 0 0	
Guy's Hospital Reports ...	88 0 0	
		395 19 1
„ Expenses—		
Students' Club Rent ...	155 7 6	
Field Rent	198 10 0	
Rates, Taxes, Gas, Water and Insurance	120 7 10	
Field Current Expenses ...	262 12 1	
Guy's Hospital Gazette Free List, 1915	28 15 0	
Gazette Committee, to account of Loan	24 17 11	
Subscription to University of London Athletic Union	5 5 0	
Production of Year Book ...	20 0 0	
Secretarial Expenses ...	39 1 7	
Printing and Stationery and Sundries	5 7 11	
Auditors' Fee	5 5 0	
Income Tax on Deposit Interest to 5th April, 1914...	0 15 3	
		866 5 1
„ Balance, being excess of Income over Expenditure ...		170 15 9
		£1,432 19 11

Income.

	£ s. d.	£ s. d.
By Subscriptions	1,082 10 3	
Do. from Patron	1 1 0	
		1,083 11 3
„ Sundry Receipts—		
Grant from Medical School...	200 0 0	
Do. Dental School ...	20 0 0	
Rent from Tenants ...	75 0 0	
Rent from Lockers ...	5 2 6	
Interest on Bank Deposit Account ...	12 10 11	
Interest on Investment	20 3 9	
		332 17 2
„ Refunds from Constituent Institutions—		
Association Football Club	3 6 5	
Lawn Tennis Club (1911–12)	2 3 6	
Lawn Tennis Club ...	11 1 7	
		16 11 6
		£1,432 19 11

Note.—A number of the Constituent Institutions have not rendered an account of their financial position to the Clubs' Union Council for the year under review, and in consequence thereof no grants have been made. Power has been given, however, to the Budget Sub-Committee to make grants where required, but the grant in no case to exceed that of the previous year.

Audited with the books and vouchers of the Clubs' Union, and found to be in accordance therewith.

CHATTERIS NICHOLS & CO.,
Chartered Accountants,
21st April, 1915. Auditors.

The Council of the Clubs' Union.

President:
G. Newton Pitt, M.D.

Chairman:
F. J. Steward, M.S.

Sir Alfred Fripp, K.C.V.O., C.B., M.S.
R. P. Rowlands, M.S.
H. C. Cameron, M.D.
E. Biddle.
B. Burnside.
L. H. Dixon.
G. E. Kidman.
W. J. R. Viljoen.

Treasurer:
R. Davies-Colley, M.C.

Secretary:
L. Bromley, M.C.
(To be succeeded by W. E. Tanner, M.B., B.S., pending appointment to the Council by the School).

Assistant Secretary:
M. B M. Tweed.

Auditors of Clubs' Union Accounts:
Messrs. Chatteris Nichols & Co., Chartered Accountants.

Auditors of Constituent Institutions Accounts:
L. H. Dixon. M. B. M. Tweed.

Visceroptosis.

CLINICAL LECTURE BY ARTHUR F. HERTZ, M.D.

(Continued from page 289.)

Treatment.—Much can be done to prevent visceroptosis and the associated constipation in women by proper management of the puerperium. The patient should remain in bed for the first twelve or fourteen days after parturition; or, when much bruising has occurred, especially in the case of primiparæ, for as long as three or four weeks. The first few days after getting up should be spent for the most part on a couch, and a return to full physical activity should only be permitted after six weeks.

Visceroptosis due to insufficient development of the thorax requires no special treatment. In all other cases the first indication is to raise the intra-abdominal pressure. In order to do this the condition of the abdominal and pelvic muscles must be improved. Exercise and Swedish gymnastics are of great value; massage and faradism are less useful. It is essential to prevent the over-stretching of the muscles which occurs whenever the erect position is assumed, as it is impossible for them to regain their normal tone so long as they have to bear the weight of the viscera for the greater part of every day. In almost all cases, therefore, an abdominal support is required. It has sometimes been taught that a support should only be worn when the abdominal muscles are so weak that their recovery is unlikely, as improvement in the condition of the muscles is supposed to be rendered impossible by the disuse-atrophy, which the support is believed to cause. This view is, however, erroneous; by relieving the abdominal muscles of the weight of the viscera, a support prevents them from being stretched, with the result that they generally regain much of their former strength. A support, moreover, often gives so much relief to the abdominal discomfort caused by visceroptosis that it enables a patient to eat more without fear of discomfort and to take more exercise, and so indirectly helps to overcome the sluggish action of the intestines, which may be present in addition to dyschezia.

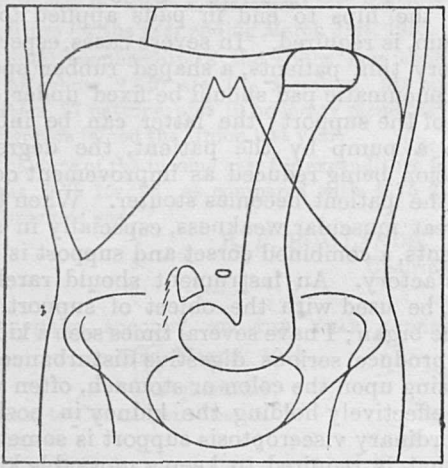
An abominal support should fit closely to the symphysis pubis and Poupart's ligaments below; above it should not extend higher than the umbilicus. It should be so made that it presses the abdominal contents upwards, backwards and inwards. It is essential that it should fit well and cause no discomfort. In mild cases of visceroptosis in women all that is necessary is a special straight fronted corset, which does not constrict the waist, but supports the lower part of the abdomen. In most cases, however, a light support, hinged in the middle line and fixed in position by steel springs, which pass over the hips to end in pads applied to the sacrum, is required. In severe cases, especially in very thin patients, a shaped rubber sponge or a pneumatic pad should be fixed under each side of the support; the latter can be inflated with a pump by the patient, the degree of inflation being reduced as improvement occurs and the patient becomes stouter. When there is great muscular weakness, especially in stout patients, a combined corset and support is most satisfactory. An instrument should rarely, if ever, be used with the object of supporting a single organ; I have several times seen a kidney-pad produce serious digestive disturbances by pressing upon the colon or stomach, often without effectively holding the kidney in position. An ordinary visceroptosis support is sometimes all that is required to keep a moveable kidney in position, but it may be necessary to have an extension with or without a pad added to the support.

The abdominal support should always be put on when the patient is lying down with the pelvis raised, so that the organs are held in proper position, and it should be worn all day. Not infrequently, however, the x-rays show that the stomach and colon drop on standing almost or quite as far when the support is worn as without it. This is particularly likely to occur in cases in which an organ falls into the true pelvis, as the support does not then reach low enough, and in thin patients, upon whom it is impossible to exert sufficient pressure. In such cases, indeed, I have sometimes observed with the x-rays that the support actually holds the organ down, and prevents it from rising when the horizontal position is assumed. I have, however, often found that such a patient derives great benefit from wearing a support, although it does not hold the colon or stomach up at all. This shows that it acts chiefly by increasing the intra-abdominal pressure, and that many of the symptoms ascribed to kinks are really the result of the low intra-abdominal pressure interfering with the circulation and with the proper performances of defæcation. It has, for example, been frequently said that mild cases of the so-called "ileal kink" can be relieved by the mechanical effort of an abdominal support,

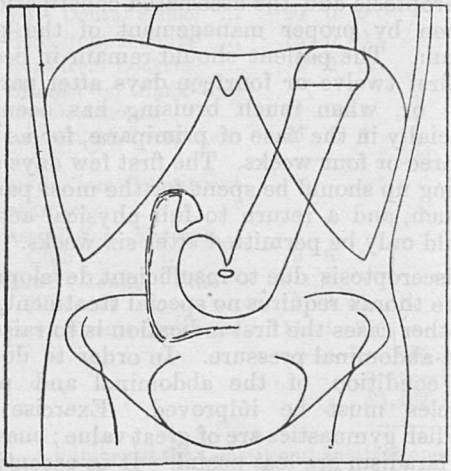
which holds the cæcum up and prevents its development. No radiographic evidence, however, has ever been published to show that it does this, and my own observations show that nothing will keep a cæcum in the right iliac fossa, if it requires manipulation to raise it out of the pelvis on lying down, and that it is rare for a support to hold it out of the pelvis even in cases in which it only falls from the right iliac fossa on assuming the vertical position. The effect of the support is thus general and not local in a large majority of cases.

When visceroptosis is due in part to weakness of the pelvic floor, this may require treatment by pessaries and local operations, which have the object of restoring the injured parts to a more normal condition, but an exercise for the levator ani muscles is often of great value in such cases: the patient is instructed to perform the movement she would make were she attempting to overcome an urgent desire to defæcate. The exercise should be repeated about thirty times twice a day while in the recumbent position. I have often seen a tendency to prolapse of the rectum and of the uterus overcome in this way, the associated dyschezia being cured at the same time.

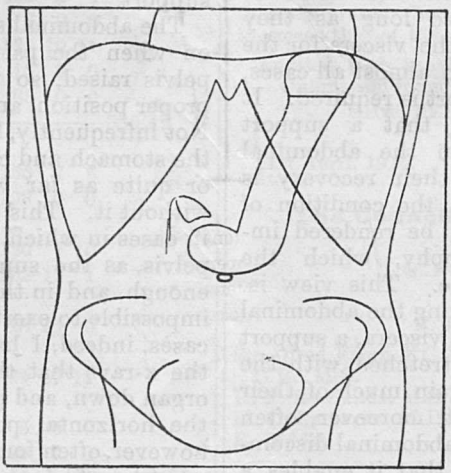
In slight cases of gastroptosis the patient



(*a*)
January 21st, 1913.



(*b*)
March 25th, 1914.



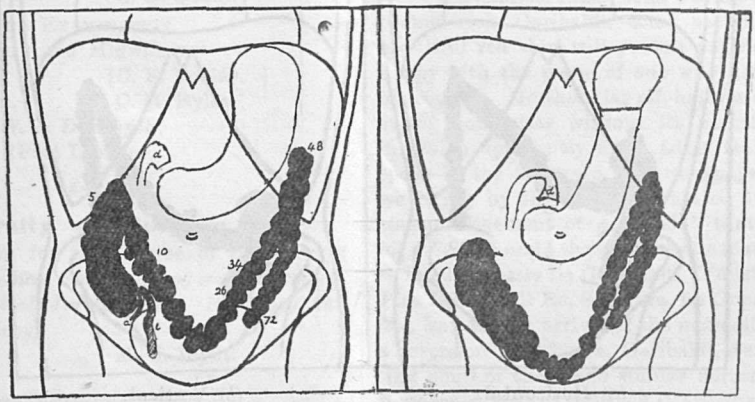
(*c*)
July 21st, 1914.

FIG. 6. Gastroptosis cured by treatment.

should lie down after meals, but in severe cases, in which there is much emaciation or the abdominal muscles are greatly atrophied, it is best for him to remain in bed for some weeks, as by this means the intra-abdominal pressure is reduced to a minimum, and all tension is removed from the abdominal and pelvic muscles. The foot of the bed should be raised as high as possible, as this helps the organs to return to their proper position, which is often maintained after the patient gets up again, especially if he gains weight during the rest.

He should lie on his right side during and for an hour after meals. He should only sit up to open his bowels and to wash when his stomach is empty before breakfast, and even then a pad should be bandaged over the lower part of the abdomen so that the stomach should not drop. After the complete rest is over he should continue to wear an abdominal support and should at first lie for an hour on his right side after meals. Small meals should be given at frequent intervals and food should be chosen which contains a maximum of nourishment in a minimum of bulk. Upward massage is useful, especially if the stomach or colon is low in the horizontal as well as in the vertical position. It is most effective if the masseuse gives her first treatment under the X-ray screen, so that she can see what manipulations are required to bring the stomach and colon back to their normal position.

Gastroptosis cured by treatment.—An unmarried lady, aged 52, suffered from indigestion, severe constipation, and general weakness. The tone of her stomach was found to be normal, but a considerable degree of ptosis was present (Fig. 6) (*a*), which was due to the very flabby condition of her abdominal muscles. She was given an abdominal support and had regular massage and exercises, with the result that the condition of her muscles steadily improved in spite of the fact that she had no rest in bed. The position of her stomach had risen to normal, when I saw her fourteen months after the first examination (*b*). She was now able to do without aperients, but still used a little paraffin; she then gave up the abdominal support, but continued to have massage at intervals, with the result that four months later the stomach had actually become slightly hypertonic, the greater curvature being just above the umbilicus (*c*). She was now also able to get her bowels open without even using paraffin.



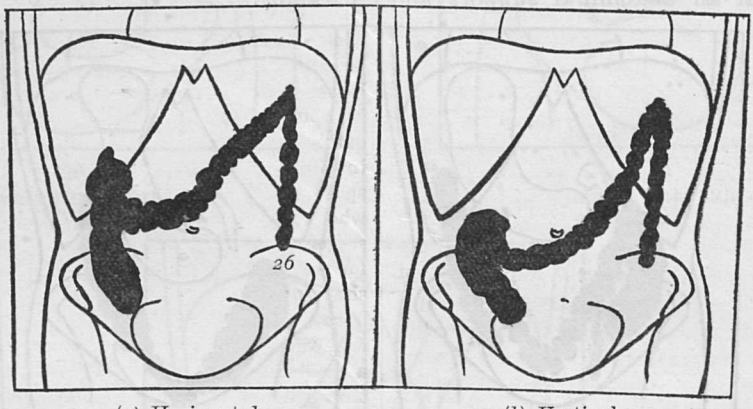
(*a*) Horizontal. (*b*) Vertical.

FIG. 7. Severe coloptosis with stasis. Before treatment, composite tracings showing outline of stomach and duodenal bulb (*d*), and shadows of terminal ileum (*i*), appendix (*a*), and colon. The numbers represent the hours which had elapsed after the barium meal, when the different parts of the bowel were reached. The ileum was not empty until forty-eight hours had elapsed, and the cæcum was still full after seventy-two hours.

Ptosis of the colon with severe intestinal stasis and symptoms of intoxication cured by rest and massage.—A girl, aged 14, had suffered from constipation since infancy. It had been getting worse the last few years, during which she had had five attacks of fæcal obstruction. Her stools constantly contained mucus. She suffered from constant headaches, pains in her limbs and body, and she had an exceedingly small appetite. Her breath was always foul and her tongue furred; she was very depressed and irritable. An X-ray examination (Fig. 7) showed that there was no stasis in her stomach, but a slight degree in the end of the ileum. There was an extreme degree of stasis through the

whole colon. The transverse colon was very low even in the horizontal position. The ptosis was probably due to the accumulation of large quantities of fæces in it, because no other organ had dropped with it. The intestinal stasis, the ptosis of the colon and the toxic symptoms were so severe that a continuation of medical treatment was only advised as a forlorn hope, and it was expected that a colectomy would ultimately be required. The patient was kept in bed for five weeks Every morning after her bowels had been opened she was given abdominal massage by a nurse, who had been shown under the X-rays how she could manipulate the colon into its normal position. She was ordered a tablespoonful of liquid paraffin after each meal, and an enema of warm water every morning. A pint and a half was used at first, but the quantity was reduced every day by half an ounce. She was made to take full diet with extra milk and cream. She improved with remarkable rapidity, and when seen six weeks after the beginning of the treatment her weight had increased from 7st. 12lbs. to 9st. 7lbs., she looked and felt better than ever before, and her mother said her character had quite changed, as she was brighter and better tempered than she had been for years. During the last fortnight of treatment the bowels had been opened naturally every morning; she still took half an ounce of liquid paraffin three times a day, and a small enema was given each evening with very little result, showing that the natural action in the morning was sufficient. The enemata were therefore discontinued, and an X-ray examination a week later (Fig. 8), after she had given up the paraffin for three days, showed that there was no longer any ileal or colic stasis, some of the barium sulphate being passed the morning after the barium breakfast. The transverse colon had risen to its normal position, dropping only just below the umbilicus on standing; before the treatment began its lowest point, measured orthodiagraphically, was 4in. below the umbilicus on standing. Four months after she had got up she was getting her bowels open with paraffin and a little aloin; she had gained a few pounds more in weight, and her general health continued to be excellent.

Under no circumstances should any operation be performed for fixing dropped viscera, except incidentally in the case of the cæcum, when an appendicostomy or cæcostomy is performed, and in certain cases of nephroptosis. As it is unusual for one organ to drop alone, the effect of such operations is rarely permanent, and the neurasthenic condition of many of the patients makes surgical interference of any kind most undesirable. The only exception to this rule is in cases of a moveable kidney, in which serious symptoms have resulted from obstruction of the ureter or blood-vessels, or the only symptom is pain in the loin which disappears completely on lying down, and an abdominal support has not given relief. Short-circuiting operations are very rarely required for the purpose of overcoming kinks in the alimentary canal. Gastro-enterostomy is never followed by any improvement in cases of gastroptosis; in rare cases of severe kinking at the splenic flexure a short-circuiting operation, such as an anastomosis between its limbs, may be required and the



(*a*) Horizontal. (*b*) Vertical.

FIG. 8. Tracings from same case as Fig. 7, taken four months later, twenty-six hours after a barium meal; some of the barium had already been passed.

results obtained are generally satisfactory, as in one case of the sort upon which Mr. F. J. Steward operated for me, but as a rule the use of enemata gives complete relief.

NOTE.—We regret that the illustration Fig. 4 (*b*), page 287, in the first part of this lecture, was inadvertently placed upside down.

Pass List.

University of Cambridge.

At Examinations for Medical and Surgical Degrees held recently, the following candidates were successful.

SECOND EXAMINATION, PART II.

Pharmacology and General Pathology.

P. D. Chapman. R. E. Jerwood.
S. M. M. Jabir. C. L. Odam.

THIRD EXAMINATION.

Surgery and Midwifery.

†G. L. Attwater. †C. F. Pedley.
R. W. P. Jackson. C. M. Ryley.
†W. J. D. Smyth.

†Part I. only.

University of Durham.

Third Examination for the Degree of Bachelor of Medicine (*Materia Medica, Pharmacology and Pharmacy, Public Health, Medical Jurisprudence, Pathology and Elementary Bacteriology*).

J. A. Berry. M. C. Joynt.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR,—I am sure hundreds of your readers will be anxious to second your vote of thanks to Mr. Tanner, the late Editor.

On all hands one has heard volumes of complimentary remarks about the improvement of the GAZETTE. He has undoubtedly raised it to a very high standard of efficiency.

Out here in France, the arrival of the GAZETTE has been something to look forward to, and it has been greatly appreciated by many on active service who do not belong to Guy's.

May I be allowed to express my very genuine regret that the time has arrived for him to hand over the editorship, and to wish him every success in his new appointment.—I am, yours faithfully,

July 10th, 1915. AN OLD GUY'S MAN.

Viva L'Italia!

Naples, May 29th, 1915.

"War at last," said a man next to me as we jostled each other; hot and sweating, somewhere at the tail of the latest demonstration—"Thank heaven for that," and by his tone he obviously implied—Now for a little peace and quietness. For life has been a strenuous business for the patriotic Neapolitan just lately. What with several patriotic demonstrations per diem, each one more imposing than the last, all with their inevitable crowds of black-coated, anæmic students, waving little paper tricolours, issued as a *réclame* by an enterprising commercial house, the breathless purchase of each of the seventeen "extraordinary" editions of the five daily papers, plus the authoritative sheets which come in at intervals from Milan and Rome, and the filling in of odd moments with the singing of the Italian "Tipperary"

Torna, torna, Garibaldi, torna!
La camicia rossa, bella e santa ci proteggerà.

(Come back, Garibaldi, come back! The sacred and beautiful red shirt will protect us), he would go to bed happy with the peace of one who has deserved well of his country. In those far off, halcyon days, no students' eating house was without its nightly speech-making, in which apparently every adult Italian thought and spoke in the language of a newspaper leading article, where day by day we congratulated ourselves upon the stagemanagement of a "crisis" that promised to last for ever, and amid the enthusiastic toasting of the Allies, shouted "*Abasso* La Germania, L'Austria, Giolitti; and *Viva* L'Italia. Il Re, Salandra, La Guerra, L'Inghilterra, &c., &c., till the arrival of the mandoline players caused a reversion to "Torna, Garibaldi, &c." The culminating point of these and similar horrors of peace was a threatened visit of Gabriele D'Annunzio (here he is only referred to as "Il Poeta") though eventually Naples was spared this epoch-making experience. I am free to confess at this stage I fled into the wilderness . . . ,

A sweeping plain, bounded on one side by the Southern Appenines, their lower slopes wooded, higher bare rock, still harbouring in its hollows the gleam of a little snow, on the other the matchless ultramarine of the Mediterranean. North and south, as far as the eye could see, the dusty luxuriance of the Italian *campagna*, and in its midst, standing in majestic isolation, the crumbling relics of an ancient city, temples, walls, amphitheatres, watch-towers, desolate in the fever-breeding richness of a malarial swamp. A few scattered hovels, a village wine-shop, a farm building or two, built with huge incongruous blocks pillaged from the ruins, and the road, a white morass of dust, stretching away to infinity. This is Paestum, the greatest city of Magna Graecia, twenty-four centuries ago. Nothing breaks the stillness save the rustling of some snake in the bush grass, and in the beating sunglare the lizards dart to and fro on mysterious errands. And there were we, commonplace tourists, utterly banal in our equipments of guide books, cameras,

sketching blocks and luncheon paraphernalia. Four of us, myself and three of that interesting class the war has produced in large numbers here in Italy, Germans furnished with English guide books, Dutch passports, and speaking among themselves (when anyone is in earshot) a picturesque language which they imagine to be the English tongue; occasionally, with Teutonic thoroughness, they carry on their persons miniature Union Jacks. Seated in front of the largest temple I listened to their guileless chatter and watched the female of the species toiling in the hot sun, preparing a colossal repast, truly German in its frightfulness. Then officialdom in its fine flower, a procession of *carabinieri*, constables and hangers on, a collection of twenty or so persons, appeared winding through the greenery. At a respectful distance the spokesman, mopping his brows, explained with a wealth of gesture that photographing or sketching the ruins was forbidden, had been forbidden for six weeks or more. The Germans were righteously indignant, producing cards from Berlin Art Schools testifying to the utter purity of their motives. With a fluency, equalled only by the badness of their Italian, they anathematized a Government which could in mistaken ideas of self defence put these obstacles in the way of humble students of the arts. The spokesman smiled wanly, and consulted with his cohort. I, having taken all the photographs I needed, sat on my camera and spurred on the Germans to further efforts. At last, with the air of Solomon, he delivered himself of this judgment—"Since you have started you may complete your sketch of the temple, provided it takes only one hour, and you do not sketch *any of the grass around it.*" "But," said the Teuton, "I wish to do it in colour, an hour is not nearly enough." "That can be done as well and indeed more easily at home" replied Solomon, thinking doubtless of his childhood's days; "Why cannot you be like the Signore here (indicating myself) who does not argue, but is content to obey?" And he left us to ponder, as on the decrees of Providence.

Then it was that I did the forbidden thing. The afternoon was hot, the sea at hand, the beach empty, inviting. Four hours separated me from the second and last of the day's trains. I bathed.

But returning several hours later to the station, I found Solomon and his cohort awaiting me. "Aha—said he—where have you been, it is now nearly four hours since you left the temple." I informed him innocently of my bathe. Had I known I would have sooner fabricated a story of child murder. He snorted indignantly and the cohort sniggered. "But it is well known that no one but a madman would bathe now; in July, August perhaps;" he spoke with the air of one who countenances but does not approve the weaknesses of others. "Also, produce your papers." Here was indeed the *fons et origo*. For no Englishman, I take it, ever fully acquires what one may call the identification habit. Every Continental is prepared to prove at a moment's notice the christian name of his wife's grandmother, the date on which his ather firs made a break of twenty-six at snooker pool, and the day of the week on which he himself gained a prize for mental arithmetic. However, I succeeded in producing a tube ticket from Earl's Court to Victoria, two latch keys, and a list of the articulations of the sphenoid bone; which last was regarded as a damning bit of evidence. Solomon took counsel. "I am sorry, Signore," he said at length, "but I must ask you to come with us to Salerno (the local metropolis), it is the merest formaiity, you will doubtless be able to establish your identity in a few moments, but you understand, that in a moment such as this when the very destinies of Italy hang in the balance . . . ." but here, brave fellow, the patriot in him rose uppermost, and for a quarter of an hour we had a leading article, punctuated by the Bravos! of the cohort.

In Italy, when people talk of a few moments, you know that they are speaking figuratively. In my case it extended to two nights and a day in the local jail, and competent observers put this down as a lightning revolution of the wheels of justice. Some of their stories had an unmistakably Count of Monte Christo flavour. And what I didn't know about the prison taint wasn't worth the knowing. In this respect an Italian prison in the hot weather must be almost unexcelled. My entrance was conducted with that tact which makes the Italian among the greatest of the world's diplomatists. At Salerno, naturally enough, I was interviewed, cross-questioned, and examined by everyone who had five minutes to spare. The *questura*, a sort of *juge d'instruction*, treated me with old-world courtesy. I was made to feel an honoured guest rather than a suspected German. "But," he said, "I'm afraid I must ask you to spend the night with us; I am arranging for a room for you at our expense, where I am sure you will be very comfortable." And so, after a walk with a friendly constable I was suddenly pushed through a dark archway and the prison gate clanged behind. My examination was, or rather would have been, a humorous affair, if it had not followed upon one of the most uncomfortable nights I have ever spent. Even a cell ten feet by twelve can harbour a fauna variegated and interesting. Moreover, soap is deemed a luxury beyond the humble needs of the malefactor. The governor of the prison was a bright individual, who took an artistic pride in the amusement of his charges. My examination he conducted on the lines of a dumb show.

For example: "You are ——?"—accompanying this with a gesture not admitted, I am sure, in the best Salernian circles, to which I replied that I was as yet unwed. My complaint about the bugs provoked him to speech. "It is not your Hotel Cecil here, you know." to which I could but agree.

Prison life is not dull. This is my day's programme—12 midnight to 6 a.m. Three church clocks every fifteen minutes.

6 a.m.—Roused (!) by warder.

7 a.m.—Visited by prison doctor.

7.15 a.m.—Visited by prison chaplain.

7.30 a.m.—Interviewed by prisoner in for life, who said he spoke English.

8 a.m.—Interviewed by deputy governor.

8.30 a.m.—Interviewed by governor.

9 a.m.—Shaved by prison barber.

10 a.m.—Fed for the day.

1 p.m.—Exercised in prison yard.

3 p.m.—Again interviewed by governor.

3.30 p.m.—Tempted cat through prison bars with remains of meal. Cat, wise beast, refused.

4 p.m.—Prison bars and walls tested by a posse of six warders. *No laughing matter.*

4.30–6.30 p.m.—Looked for spider. Decided Robert Bruce must have had special treatment.

7.30 p.m.—Presented with light, which must on no account be extinguished.

8 p.m.—Commanded to go to bed.

8.30 p.m.—Church bells re-commence.

So you see it was quite a busy time.

Next morning, at 9 a.m., they released me without apology, but with more leading article. I regret to say I lost my temper, and told them bitter truths. Three miles further on, however, the next town arrested me on the suspicion of being an unlawful vagabond, and I had to apply to my former jailors for a character. Unfortunately I never knew what they said!

When I got back to Naples I saw in one of the papers that at Torre del Greco, an outlying suburb, two Italian commercial travellers from Bologna, who had gone there to take dinner in the open, were taken for German spies by an infuriated mob, and only the opportune arrival of the carabinieri saved them from death by dismemberment.

The citizens, cheated of their prey, then found an old man of seventy from Portici, a village two miles off, and pursued him with sticks and stones till he was forced to take refuge. I do not fancy the town will have much of a tourist season this year, but it certainly merits the honour of a star in Baedeker.

G. H. F. G.

Change of Address.

J. M. Barnes, L.D.S., 74, Denmark Villas, Hove.

A. E. Lowein, L.D.S., 1, Cedars Road, Clapham Common, S.W.

Lieutenant H. W. Evans, R.A.M.C., Officers Mess, 37th Divisional Field Ambulance, Tidworth Park Camp, Tidworth, Wilts.

Lieutenant W. B. Farrington, 3rd Sherwood Foresters, 9, Park Avenue, Roker, Sunderland.

A. Harris, 53, Welbeck Street, W.

Lieutenant S. S. B. Harrison, R.A.M.C., 3rd Field Ambulance, 46th Division, Brit. Exped. Force.

Lieutenant D. C. Scott, R.A.M.C., 35th Field Ambulance, 11th Division, Brit. Mediterranean Exped. Force.

Captain M. A. Rahman, I.M.S., c/o Messrs. Grindlay & Co., Bombay, India.

The New Guy's Pharmacopœia.

THROAT AND EAR FORMULÆ.

GARGARISMA CHLORI, Chlorine Gargle.

Take of

Potassium Chlorate, in powder,	6 Dg. ...	10 gr.
Hydrochloric Acid	3 Dl. ...	5 min.

Mix in a dry bottle, and let the gas generated replace the air in the bottle; then put the stopper in the bottle, and let it stand for two minutes; lastly add gradually

Water to	30 Ml. ...	1 fl. oz.

Just before use add 4 mils (1 fluid drachm) of Syrup of Citric Acid to every 30 mils (1 fluid ounce) of the Gargle.

GARGARISMA POTASSII CHLORATIS, Chlorate of Potash Gargle.

Take of

Potassium Chlorate	6 Dg. ...	10 gr.
Water to	30 Ml. ...	1 fl. oz.

Dissolve.

INJECTIO AMYDRICAINÆ ANÆSTHETICA, Anæsthetic Injection of Amydricaine, is a 10% solution of Amydricaine Hydrochloride in sterilised Distilled Water, —approximately 44 grains in 1 fluid ounce.

INSUFFLATIO BENZOCAINÆ ET ORTHOCAINÆ, Insufflation of Benzocaine and Orthocaine.

Take of

Benzocaine (20)	6 Cg ...	1 gr.
Orthocaine (20)	6 Cg ...	1 gr.
Starch, in powder, to (100) ...	30 Cg ...	5 gr.

Mix for an Insufflation.

INSUFFLATIO ORTHOCAINÆ, Insufflation of Orthocaine, 20%.

Take of

Orthocaine (20)	6 Cg. ...	1 gr.
Starch, in powder, to (100) ...	30 Cg. ...	5 gr.

Mix for an Insufflation.

LIQUOR ALUMINII ACETATIS, B.P.C., *Solution of Aluminium* Acetate, 8%, is made from Aluminium Sulphate, Acetic Acid, Precipitated Calcium Carbonate, Distilled Water.

LOTIO ALKALINA COMPOSITA, Compound Alkaline Lotion.

Take of

Compound Alkaline Powder (2)	5 Dg. ...	8 gr.
Carbolic Acid Lotion (10) ...	3 Ml. ...	45 min.
Distilled Water to (100) ...	30 Ml. ...	1 fl. oz.

Dissolve and mix.

NEBULA ALKALINA, Alkaline Spray.

Take of

Compound Alkaline Powder (4)	11 Dg. ...	16 gr.
Distilled Water to (100) ...	30 Ml. ...	1 fl. oz.

Dissolve.

NEBULA IODI COMPOSITA, B.P.C., Compound Iodine Spray, contains Iodine, 1%, Phenol, 1%, dissolved in Liquid Paraffin.

NEBULA MENTHOL ET THYMOL COMPOSITA, B.P.C., Compound Menthol and Thymol Spray, contains Menthol, Thymol, Camphor, Phenol, 2% of each, dissolved in Liquid Paraffin.

PASTILLUS BENZOCAINÆ, Benzocaine Pastille, contains 6 Cg. (1 gr.) of Benzocaine in Glycogelatin.

Dose: 1 Pastille.

PASTILLUS MENTHOL ET EUCALYPTOL, B.P.C., Menthol and Eucalyptol Pastille, contains 3 Mg. ($\frac{1}{20}$ gr.) of Menthol, and 3 Cl. ($\frac{1}{2}$ min.) of Eucalyptol.

Dose: 1 Pastille.

PASTILLUS ORTHOCAINÆ, Orthocaine Pastille, contains 12 Cg. (2 gr.) of Orthocaine in Glycogelatin.

Dose: 1 Pastille.

PASTILLUS POTASSII CHLORATIS, Potassium Chlorate Pastille, contains 20 Cg. (3 gr.) of Potassium Chlorate in Glycogelatin.

Dose: 1 Pastille.

PASTILLUS POTASSII CHLORATIS ET COCAINÆ, Potassium Chlorate and Cocaine Pastille, contains 20 Cg. (3 gr.) of Potassium Chlorate, and 8 Mg. ($\frac{1}{8}$ gr.) of Cocaine Hydrochloride.

Dose: 1 Pastille.

PULVIS ACIDI SALICYLICI ET BORICI, Salicylic and Boric Acid Powder.

Take of

Salicylic Acid, in powder, (20)	6 G.	90 gr.
Boric Acid, in powder, to (100)	30 G.	1 oz.

Mix.

PULVIS ALKALINUS COMPOSITUS, B.P.C., Compound Alkaline Powder, consists of equal parts of Sodium Bicarbonate, Sodium Chloride, and Purified Borax.

Directions for use: 2 to 4 grammes (30 to 60 grains) to be dissolved in 300 mils (10 fluid ounces) of warm water to make a Nasal Wash.

PULVIS AZONAPHTHOL BORICUS, Scarlet Red and Boric Acid Powder.

Take of

Azonaphthol (20)	6 G.	90 gr.
Boric Acid, in powder, to (100)	30 G.	1 oz.

Mix.

PULVIS IODOFORMI ET ACIDI BORICI, Iodoform and Boric Acid Powder.

Take of

Iodoform, in powder, (25)	7·5 G.	110 gr.
Boric Acid, in powder, to (100)	30 G.	1 oz.

Mix.

TABLETTÆ FORMALDEHYDI, Formaldehyde Throat Tablets.

Take of

Solution of Formaldehyde	3 Cl.	$\frac{1}{2}$ min.
Gluside	0·4 Mg.	$\frac{1}{150}$ gr.
Citric Acid	20 Mg.	$\frac{3}{10}$ gr.
Gum Acacia, in powder	6 Cg.	$1\frac{1}{2}$ gr.
Milk Sugar	30 Cg.	5 gr.
Oil of Lemon	0·6 Cl.	$\frac{1}{10}$ min.
Refined Sugar, in powder, to	1 G.	15 gr.

Granulate and compress into one tablet.

Dose: 1 to 6 tablets.

UNGUENTUM AZONAPHTHOL, Scarlet Red Ointment, 4%.

Take of

Azonaphthol (4)	1·5 G.	22 gr.
Prepared Lard to (100)	30 G.	1 oz.

Dissolve the Azonaphthol in the previously melted Lard; stir until cold.

VAPOR BENZOINI, Inhalation of Benzoin.

Take of

Compound Tincture of Benzoin	4 Ml.	1 fl. dr.
Water at 60° (140° F)	600 Ml.	1 pint

Directions for use: Mix the Tincture and Water in an apparatus so arranged that air may be made to pass through the solution, and may afterwards be inhaled.

VAPOR CRESOL COMPOSITUS, B.P.C., Compound Cresol Inhalation, contains Creosote, Oil of Eucalyptus, Oil of Siberian Fir, Cresol.

Directions for use: A small quantity of the Fluid to be poured into a metal vessel, and volatilised by heat.

VAPOR IODI ÆTHEREUS, B.P.C., Ethereal Inhalation of Iodine, contains Ethereal Tincture of Iodine, Phenol, Creosote, Alcohol.

Directions for use: About 10 drops to be used on the absorbent pad, or sponge, of an oro-nasal respirator.

VAPOR OLEI ABIETIS, B.P.C., Pine Oil Inhalation.

Directions for use: Put 4 mils (1 fluid drachm) of the Inhalation with 300 mils (half a pint) of cold water and 300 mils (half a pint) of boiling water into an apparatus so arranged that air may be made to pass through the liquid, and may afterwards be inhaled.

Papers by Guy's Men.

Sir James F. Goodhart, Bart., M.D. Aberd., F.R.C.P.: The right-sided murmurs of mitral stenosis; their bearing on the course of the disease.—*Lancet*, July 3rd, 1915.

J. M. Fortescue-Brickdale, M.B., D.M. Oxon., M.R.C.P. Lond.: A case of congenital hemihypertrophy.—*Ibid.*

A. H. Tubby, M.S., F.R.C.S.: Orthopœdic Surgery.—*Practitioner*, July 1915.

Kenneth Black, F.R.C.S.: Two cases of phlegmonous duodenitis.—*Ibid.*

The National Health Insurance Act.

IN July, three years will have passed since the above Act came into force. Its application to domestic servants was, as our readers will remember, more bitterly resented than to any other section of society.

In their opposition to the "tax," as it is still described in many newspapers, "above and below stairs" were united in the difficulties of spelling iniquitous as they wrote severally to *The Times* or *News of the World*. It is, therefore, of interest to note that domestic servants will be the first class to receive from the Act increased benefits.

The *Westminster Gazette* says:—

"The fortunate approved society which is the first to be able to give larger benefits, without increasing the members' contribution, is the Domestic Servants' Insurance Society, which was formed on the initiative of Lady St. Helier when the Act first came into force

"On and after June 1 all the female domestic servants who are members of that society will receive the privilege of free dentistry whenever they require it, in addition to the five ordinary benefits that they have been receiving under the Insurance Act for some time past.

"The society has had a career of uninterrupted prosperity during the last three years, and has been able to accumulate very large surpluses on its benefit account and also on its administration account, and it is this latter surplus which is being used to finance the new benefit.

"The membership of the society, Lady St. Helier tells us, is now in the neighbourhood of 75,000, and shows signs of increasing so rapidly that it has been found necessary to take larger premises at 439 and 441, Oxford Street, London, W. (immediately opposite Selfridge's).

"To organise free dentistry for these 75,000 members is a task of the first magnitude, and arrangements have been made to cope with an enormous number of patients within the next few months. London members will have the benefit of free dental surgery at a special clinic which has been established and equipped in the most up-to-date fashion, and has at its disposal all the latest improvements of dental science. In the provinces arrangements have been made with registered dentists all over the country to treat members of the society whenever necessary. The whole of this is being done without a farthing being added to the contributions.

"There have been grave complaints from some of the approved societies as to the heavy drain on their funds, but however true this may be, there are evidently a number of approved societies which, whether by efficient administration or exceptional good luck, have been able to accumulate substantial surpluses. We may, therefore, expect in the near future a considerable extension in the benefits paid under the Insurance Act, and those societies, such as the Domestic Servants' Insurance Society, which are fortunate enough to be able to give large additional benefits, will doubtless obtain a very considerable number of new members, and since insured persons have a free right to transfer from one society to another, they will, without doubt, increase their membership at the expense of societies less fortunately situated."

The Residents' Tennis Party.

On Wednesday, July 7th, the Residents held their first tennis party on the Clubs' Union Ground at Honor Oak Park. The climatic conditions were anything but favourable, but in spite of this, the Matron, Sisters Patience, Addison, Stephen and Astley Cooper, braved the elements.

The first part of the afternoon was spent by a good many people in estimating the tension of last year's racket strings, and the resilience of the balls; one foursome, however, had some very keen sets, as shown by the length of their latent period before reacting to the repeated stimuli of the tea-bell.

The boisterous wind proved an excellent appetiser for tea, especially at one end of the table, where cakes and strawberries collected and disappeared with lightning rapidity. (We regret to say that we have been compelled to dismiss our Reporter for accepting bribes to suppress names in connection with the above incident.)

After tea Sister Patience and R. Curle issued an open challenge which they maintained, although Sister Addison and R. Sells disputed the game up to 5 all.

"Asepsis" we are pleased to say followed the usual Hospital practice and triumphed over "Sepsis," although the Resident Doctors in attendance were at times a bit nervous about the ultimate result.

G.H.L.T.C. v. PUTNEY L.T.C.

This match was played on our ground on Saturday, July 10th, and resulted in a victory for Guy's by 5 matches to 4. Putney were not so strongly represented as in the previous match, when they defeated us by 6 matches to 3. All their team seemed considerably affected by the wind. For Guy's, R. R. Traill played very well, and brought off a very accurate net-cord shot when the score was match point against him! Sterne Howitt and Gill showed good form. Curle and Sells were rather short of practice. Scores:—

R. R. Traill and A. Traill beat E. A. Miller and N. Charrington, 5/7, 8/6, 6/3; beat W. Petrie and H. Webb, 6/2, 6/2; beat T. C. Orpen and W. Connelly, 6/1, 6/1.

R. Curle and R. Sells lost to Orpen and Connelly, 3/6, 4/6; lost to Petrie and Webb, 2/6, 10/12; lost to Miller and Charrington, 3/6, 3/6.

H. Sterne Howitt and L. Gill beat Petrie and Webb, 6/1, 6/1; lost to Miller and Charrington, 4/6, 3/6; beat Orpen and Connelly, 6/1, 6/3.

London Ambulance Service

In connection with the London Ambulance Service, a New Motor Ambulance Station was opened at St. George's Market, London Road, Southwark, S.E., on Monday last, July 12th. The district to be served by the new station is as follows :—

"The area bounded on the north and east by the South Bank of the River Thames from Vauxhall Bridge as far as the Gates of the Victualling Yard, thence by Windmill Lane to the Surrey Canal, along the banks of the Canal to Camberwell Road, Wyndham Road, Camberwell New Road, Harleyford Street, Kennington Oval (south-west side), Harleyford Road, Upper Kennington Lane to the south side of Vauxhall Bridge."

Appointments.

The following appointments were made by the Court on Friday last :—

As Honorary Anæsthetists to the Hospital during pleasure or until the age of 60 years: Dr. Shipway, Mr. Page.

As Anæsthetists to the Hospital for one year from October 1st, 1915: Mr. Todd, Mr. Mullally, Mr. Marshall, Mr. Pochin.

As Chemical Pathologist for one year from October 1st, 1915: Mr. Ryffel.

As Morbid Histologist for one year from October 1st, 1915: Dr. Nicholson.

As Resident Surgical Officer for one year from October 1st, 1915: Mr. J. G. Saner.

As Deputy Resident Surgical Officer for one year from October 1st, 1915: Mr. Todd.

As Assistant Dental Surgeon during pleasure or until the age of 60 years: Mr. Lewin Payne.

As Anæsthetist to the Dental School during pleasure or until the age of 60 years: Mr. Ogle.

As Assistant Dental Surgeons during pleasure or until September 30th, 1920, Mr. Dowsett, Mr. Pearce, Mr. Malleson.

As Anæsthetists to the Dental School during pleasure or until September 30th, 1920: Dr. Shipway, Mr. Page.

As Anæsthetists to the Dental School until September 30th, 1916: Mr. Mullally, Mr. Todd, Mr. Ryley.

C. H. WELLS,
July 7th, 1915. Clerk.

Royal Army Medical Corps.

Mr. A. H. Tubby, F.R.C.S., has been appointed a consulting surgeon to H. M. Forces, with the temporary rank of Colonel in the Army Medical Service, and has proceeded to the Dardanelles.

3rd Northern General Hospital:—Captain Graham S. Simpson, R.A.M.C. (T.F.), to be Major.

Lieut. W. G. Mumford to be Captain.

Percy A. Peall to be temporary Major whilst employed with the County of London War Hospital.

2nd Eastern General Hospital:—C. H. Bryant to be Captain, whose services will be available on mobilisation.

To be temporary Lieutenants:—R. D. Bridger, T. G. Stevens, J. Young, F. Heatherley, P. W. Moore, W. G. Brett.

1st London (City of London) Field Ambulance:—T. A. Townsend to be Lieutenant.

3rd Southern General Hospital:—Captain E. W. S. Rowland is seconded for duty at Reading War Hospital.

1st West Riding Field Ambulance:—T. I. Mills to be Lieutenant.

Attached to other than Medical Units.

Captain James Walker to be Major.

A. G. Osborn to be Lieutenant.

Roll of Honour.

Lieutenant W. R. Pryn, R.A.M.C., is reported as having died whilst serving with the Expeditionary Force.

Reviews, etc.

Summer Dishes.—Such is the title of a booklet published by Messrs. Brown & Polson, the well-known firm of corn flour manufacturers.

The very name conveys a vision of some dainty, appetising and refreshing dish, most acceptable on a hot sultry day when the appetite is often a little fastidious. A glance through the twenty-four pages of the book bearing the above title is enough to gladden the heart of every housewife, for here at hand she has simple instructions for the making of delightful and yet inexpensive luncheon, dinner and supper sweets. Blancmange sponge, fresh fruit jellies, chocolate custard shape, ratafia mould, fruit salads, soufflés and ices are a few of the dishes noted at random, but these do not nearly exhaust the good things that the book contains.

A post-card to Messrs. Brown & Polson, Paisley, will bring a copy of this book post free by return of post.

Births.

CROOK.—On June 30th, at The Goffs, Eastbourne, the wife of A. H. Crook, M.C., F.R.C.S., of a son.

STEINBACH.—On June 10th, at Newton House, Knaresborough, Harrogate, the wife of Horace Steinbach, M.R.C.S., L.R.C.P. Lond. (*née* Goodison, M.B., B.S. Lond.), of a daughter.

Marriage.

EDMOND—TILBURY.—On July 6th, at Southwark Cathedral, John Edmond, M.B., to Anna, daughter of John Tilbury, of Upton Gray, Hants.

Death.

CLEMENT LUCAS.—On June 30th, at Oaklands, Midhurst, Sussex, late of 50, Wimpole Street, Richard Clement Lucas, M.B., B.S. Lond., F.R.C.S. Eng., L.R.C.P., aged 69 years.

E. N. G.

GUY'S HOSPITAL GAZETTE.

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Passim.

THIS last week has been one of great importance to the Medical School for at a Meeting of the School held on Tuesday, July 27th, the President announced that only that morning arrangements had been made for the transfer of a sum of £25,000, invested in War Loan, to the Governors of the Hospital by the Directors of the Commercial Union Assurance, Ltd., acting as Trustees under the Will of the late Sir William Dunn, Bart., for the purpose of founding and endowing in the Medical School of Guy's Hospital a Lectureship in Pathology to be called the Sir William Dunn Lectureship in Pathology; and further, that Mr. Robert Gordon, to whom the School owed so much in the past, had readily agreed to place the funds given by him in 1900 for the endowment of a Lectureship in Pathology, at the disposal of the School for use in whatever way may appear most conducive to the interests of medical education at Guy's.

FOR the past few months a Committee of the Medical School have been holding meetings in order to consider the advisability of allowing female medical students to take up a course of medicine at this Hospital. At their final meeting this week they decided that there was not at present suitable accommodation at their disposal to enable them to entertain such a scheme.

This is an important decision in view of the fact that the Charing Cross Medical School have recently decided to allow female medical students to take a course of study at that Hospital.

There are few men connected with Guy's who would resent such a scheme, merely because of its being a matter of sex. There are, however, many who would oppose it for the very good reason that they have never been shown any system which would be a practical success without breaking down many old customs which date back many years, and are now, in fact, part of the Hospital itself. Then there is the question of the almost inevitable competition. Would it be beneficial to the name of Guy's?

We will pass no verdict, as we feel confident that before many years can pass the question will recur, and form the subject of many a heated argument in the GAZETTE.

WE are pleased to be able to announce that the executors of the late Mr. J. C. Eno, of Dulwich, have just informed us that Mr. Eno has bequeathed the sum of £25,000 for the general purposes of the Hospital and £25,000 for the Re-endowment Fund, both sums being free of duty.

This announcement is very gratifying to the Treasurer and Governors of the Hospital, coming, as it does, at a time when subscriptions and donations are not coming in so frequently as they did in times of peace.

WE regret to have to announce the death of 2nd Lieutenant W. A. Stanwell. 2nd Lancashire Fusiliers. Stanwell received his early education at Blundell's School, and entered Guy's in October, 1913, having passed the London Matriculation Examination in the previous July. At the outbreak of war he was working for his First M.B. (London) Examination.

He was killed in action on June 9th, and so the Hospital has lost another of her younger sons who gave up everything to go out and fight for his country. We offer our sincere sympathies to all his relations and friends.

IT was with great pleasure that we read that Lieutenant Kelsey Fry had been awarded the Military Cross. It will be remembered that Fry was attached to the Royal Welsh Fusiliers, and together with Corporal Welch of the same regiment, made such a gallant attempt to save Lieutenant Gladstone when he was wounded, by carrying him to a place of safety in full view of the Germans.

LAST week Lieutenants Miller and Attwater, R.A.M.C., who were both attached to No. 22 General Hospital in France, came up to the Hospital during their four days' leave.

No. 22 has now been occupied by an American Hospital unit. All the Guy's Sisters and fifty Guy's Nurses have been transferred to No. 26 General Hospital, situated in the same district in France. So far, we have had no news of the destination of those Guy's men who were originally attached to No. 22.

Further on will be found a letter from the Matron in which she expresses the hope that all materials which would have been sent to No. 22 should now be sent to No. 26 General Hospital. We feel confident that the hearty response which was made to her first appeal will not be influenced in any way by this change of address.

THE Wills Library will be closed for the Summer Vacation from August 5th till August 28th. The Librarian would be grateful if all borrowed books could be returned to him not later than Wednesday, August 4th.

Obituary.

Lieutenant W. R. PRYN, R.A.M.C.
Died while serving in France.

W. R. Pryn, son of Deputy Surgeon-General Pryn, came up to Guy's from Kelly's in January, 1909. As a hard and conscientious worker, examinations held no terrors for him and he had little difficulty in qualifying in the shortest possible time. He dressed to Mr. Dunn and Mr. Turner, and was Medical Ward Clerk to Dr. Hale White and Sir Cooper Perry, and Clinical Clerk to Dr. Shaw. He took his Final Conjoint Examination in January, 1914.

During his five years up at Guy's he took an active interest in the Officers' Training Corps, of which he was a member for three years, and for one season he organised the "Guy's Nomads" Rugger XV.

On leaving, he took up the post of House-Surgeon at the Guildford County Hospital. At the outbreak of war he joined the army as a Civil Surgeon, and worked for three months at a Base Hospital in Rouen. From there he became attached to the 2nd Lincolnshire Regiment and finally met his death while serving with the 9th Field Ambulance.

Pass List.

Conjoint Examination.

At the Second Professional Examination in Anatomy and Physiology held on July 1st, 2nd and 5th, the following candidates were successful:—

J. R. Cox. Sik To Wong.

At the Quarterly Examination in Practical Pharmacy held on July 8th, the following candidates were approved:

K. L. Bates E. C. de M. Morgan.

University of London.

SECOND EXAMINATION FOR MEDICAL DEGREES, Part II. Anatomy, Physiology and Pharmacology.

F. Caldecott. G. E. Kidman.
J. C. Gie. E. A. Leviseur.
E. N. Glover. E. de Robillard.
N. Kamchorn. K. M. C. Woodruff.

University of Oxford.

The following Degrees have been conferred.

B.M., B.Ch.—R. W. J. A. Cushing.

SECOND M.B.

The following candidates have been approved at the Examinations indicated:—

Materia Medica.—J. M. H. Campbell, A. Traill, D. M. P. Whitcombe.

Forensic Medicine and Hygiene.—A. G. East.

Pathology.—J. M. H. Campbell, T. E. Micklem, A. Traill, D. M. P. Whitcombe.

Medicine, Surgery, Midwifery.—R. W. J. A. Cushing.

2nd Lieut. H. B. NEELY

(3rd Battalion 1st Suffolk Regiment),

Killed in action at Ypres in April, 1915.

Educated at Lancing College and Guy's Hospital. L.D.S.

Lieut. F. AUGUSTUS LOWE

(R.N.V.R.),

Killed whilst serving in the Dardanelles, May, 1915.

Qualified at Guy's Hospital. L.D.S.

Some Experiences in Brussels during the War.

BY AN OLD GUY'S MAN.

IV.—MY ESCAPE.

After the imprisonment of M. Max and the fall of Antwerp, the Germans commenced to "civilise" the inhabitants of Brussels. They informed them through the medium of their "affiches" that it was the command of His Imperial Majesty that the Belgians should resume their normal occupation under the fatherly supervision of the German government, with, of course, the usual threat that the penalty for non-compliance would be so many marks fine, so many days' imprisonment, etc. But they neglected to explain how the resumption of commerce could be possible whilst the Government interfered with the free import of goods and material, and incidentally allowed the soldiery to pillage the shops. From what I know of the Belgian temperament I would wager that the Germanisation of Brussels has not advanced a bit since the first day of invasion. Even up to the last day that I was in the town, the soldiers were warned not to promenade singly in the Rue Haute (the unsavoury quarter of the town) as the inhabitants gave them such a warm welcome that they never reappeared in barracks.

There is also a good deal of mystery attached to the disappearance of sentries posted on the banks of the canal. Night after night they vanished; but whether they deserted or whether they were disposed of by the inhabitants it is impossible to say. Although the canal was dragged on more than one occasion, they never discovered a trace of the missing men. The evidence supports the theory of desertion, for had there been any suspicion of foul play the Germans would not have neglected the opportunity of punishing the town.

We had heard that the Germans were interning all the Englishmen in Germany, and there were constant rumours that the Kommandantur were preparing to do the same thing in Belgium, but they left us in peace until the end of November. Then one night, about 9 o'clock, two officials in civilian clothes visited the Anglo-American Club, which was under the protection the American flag. They found the place deserted, save for two or three American members, and they ransacked the books and papers under the pretext that they were seeking evidence of an English espionage organisation.

Next day they arrested several prominent members of the English colony, and during the ensuing week they imprisoned every English citizen they could lay hands on. They made no excuse for these arrests, but simply took the men wherever they could lay hands on them, and we saw no more of them. Those who escaped the first drive left their homes, and either hid themselves or managed to get over the frontier in disguise. The latter was not so difficult at that time, because the Germans had not yet closed the Belgo-Dutch frontier with the elaborate system of barbed wire and blockhouses which exists now.

A regular service of evasion was organised by the people who knew every inch of the country, and they made a very lucrative business of it.

The Germans were evidently quite aware that there were still Englishmen in hiding, and they issued an order that every member of an enemy nation was to register himself at the Kommandantur. They declared that this measure was merely in the nature of a census and no harm should happen to those who complied with the order. Many of the fugitives were foolish enough to take them at their word, and came out of their hiding places to register. They were arrested immediately, and sent off to Ruheleben next day, in many cases without the opportunity of saying good-bye to their families.

Up to this time I had remained unsuspected, and really thought that I should be able to "stick it out" and see the triumphal entry of the Allies. But when the German inhabitants of Brussels, who had fled at the beginning of the war, commenced to return to their homes, the risk of recognition made it dangerous for me to go out in the daylight. Also, the Government had imported civilian spies from Germany for the express purpose of hunting out suspected persons. Fifty marks was the reward offered for every Englishman denounced, and the chase became very keen, not only amongst the Germans, but also the scum of the town, who were always ready to gain a dishonest franc or two. To add to our discomfort, the Germans had forbidden the payment of any money to members of enemy nations, and, as a visit to the bank was out of the question, I began to find myself in sore straits. Under the circumstances life became intolerable, and I determined to clear out as soon as an opportunity presented itself.

One night on returning home I learned to my dismay that my identity as an Englishman had been discovered. I did not wait for details, but decided that it would be better to take a sporting chance of escape over the frontier than certain capture in the morning. It was the end of February, and 3 o'clock in the morning is not the cheerfullest time to set out on such a risky adventure.

In normal times 3 a.m. finds Brussels still awake. At that hour the cafés are turning out their last clients, and the streets are quite lively. But on the morning of my hurried exit the town was deserted and dark. The only living souls I encountered were the German police patrols consisting of four soldiers and a sergeant. Needless to say I did not court their attention, but hid in doorways until they had passed.

Owing to the hurried nature of my departure I had not been able to make any preparations for the journey, but fortunately I had prepared my route some

weeks previously in anticipation of a like emergency, and it was my intention to be out of the town and through the German guard lines by day-light.

I still retained my American "certificat d'identité," but, of course, it would have been useless in a district where I was so well known; in fact, it would have proved a great danger, and had I been caught with it I should have suffered the same mysterious fate as that of two fugitives who attempted to make use of similar papers. But this document was of immense service to me later on.

I found very little difficulty in passing the guard at Laeken. It was bitterly cold, and the sentries were huddled round a brazier near the guard house. One of them shouted a greeting in German as I passed. I replied in Flemish, and they took no further notice.

It was 7 o'clock and a lovely morning when I arrived at G—, a little Flemish village some 10 kilometres outside Brussels. From there I hoped to take a steam tram to J—, but I happened to meet an acquaintance who warned me that spies were travelling in every train, on the watch for people in similar cases to mine. He told me that on the previous day five young Belgians had been arrested under particularly dirty circumstances. They were all strangers to the district and had unwisely confided their troubles to an affable fellow passenger on the tram. This man offered to put them on their way, and, having led them outside the village, he signalled to the nearest German post. They were arrested and sent prisoners to Germany. So I decided to continue my journey on foot.

Arriving at J—, I was fortunate in finding a peasant who offered to give me a lift in his cart as far as W—. He stipulated that if we encountered a patrol I was to get down and walk, as his passport did not permit him to carry passengers. This was the most dismal and uncomfortable phase of my journey. The cart was springless, and the roads in a condition that can only be described as awful. We passed village after village, all burned out and destroyed. A few mounds by the roadside spoke eloquently of the fate of the villagers. This was wanton destruction such as one finds all over the unfortunate country, for it was quite away from the line of advance of the troops. We came across that later, clearly defined by the general havoc and the hundreds of broken and empty wine bottles.

We arrived at W—without mishap about 1 o'clock in the afternoon, and I was not sorry to get down and stretch my bruised joints. It was the most uncomfortable journey I have ever experienced. From W— I walked across the canal bridge to B—.

The outskirts showed considerable signs of the bombardment; most of the houses had lost their roofs, and many streets were represented by mounds of bricks and charred rafters. But the town itself was practically intact. Here and there a broken window remained unmended and the walls were chipped and pitted with bullets. On entering the town, the first building of importance is a large white painted house, the late residence of the manager of one of the neighbouring factories. It was the first house to be struck by a shell. Externally it shows very little sign. The green shutters are closed and those on the ground floor are slightly awry. Inside, it is literally disembowelled. The shell entered the house on a level with the second floor (you can see the almost symetrical hole in the wall at the side), and, tearing through the two ceilings, burst in the basement, blowing the unfortunate servant to pieces.

I presume that the inhabitants of B— were not at home when the Germans arrived, for most of the doors bear signs of having been burst open. They have been temporarily repaired, but still show split panels and the marks of heavy boots and rifle butts.

It was market day in B—, and there seemed to be no lack of food. The main street was crowded with people carrying string bags full of potatoes and carrots, and here and there a Prussian hussar bearing a mess tin full of soup and boiled beans, the sight of which reminded me that I had fasted for 16 hours. But I was anxious to get on to Antwerp, and set out again. Once more I was in luck. On the road I came across a young priest who was escorting a party of five youths to a seminary in Q—. They were in a dilapidated wagonette, and the priest not being an expert coachman, was having some trouble with his horse. The Germans had commandeered all the serviceable horses in the country, and the specimen between the shafts was reminiscent of Don Quixote's Rosinante. I offered my services as coachman, and they were gladly accepted. The priest had passports for himself and his five companions and a permit for a driver. I undertook this post, and by dint of much forcible persuasion and the aid of a stake cut from a wayside hurdle, we arrived in Antwerp in a short hour.

I had been given an address in Antwerp where I was to find someone who would put me on my way across the frontier, but, owing to my hurried departure from Brussels, I had not the opportunity to advise him, and he was "en voyage." I then found a café and ordered a meal. The "patron" was an extraordinary person. He planted himself in front of me, and during my repast he did not take his eyes off me. Eventually he inquired my nationality in very good English; I told him that I was American, and he told me that he was a German. However, he did not seem satisfied with me, and proceeded to trot to and fro from my table to the door, occasionally stopping to stare at me. At last he wrote something on a piece of paper and handed it to a boy in the street. I paid my score and departed hastily. He was not at all the sort of person whose acquaintance I was anxious to cultivate at that time.

Having missed my guide, I determined to try and bluff my way through the German post at P—. So I boarded a tram for M—, and from there on foot to the blockhouse at P—.

The military blockhouse at P—is situated in a large open space on the main road about one kilometre on the Belgian side of the frontier post. It consists of two low wooden sheds bounded on either side by immense hedges of barbed wire stretching as far as the eye can reach. These hedges are not more than 4 feet high, but in some places are as much as ten yards deep, and are very unpleasant obstacles to negociate. The road is barred fore and aft by heavy sliding bars, so that any vehicle passing through finds itself in a kind of enclosure. At the moment of my arrival a motor car was being examined, and they did it pretty thoroughly, even to the extent of emptying the petrol tanks.

The garrison consisted of a lieutenant (who might well have been the original of some of Hansi's caracatures), two sergeants, a dozen soldiers, and two female searchers. One of the sergeants, addressing me in execrable French, invited me to advance and explain my business. I told him that I wished to go to B—, in Holland, and handed him my identification paper. He showed me into one of the sheds and disappeared into the other with my paper. Inside, the shed was divided by a low partition, from behind which came the indignant voices of the two women occupants of the motor car, protesting against the ministrations of the female searchers. If their ordeal was as severe as mine, and judging from their disarrayed toilets and hair when they emerged, it had been, they have my sympathy. I was seized by two burly ruffians in stained uniforms, one of whom helped me out of my garments, and the other turned out the contents of my pockets and heaped them on the table.

When they had reduced me to a state of nature, the humourist of the party inquired if I had any books or papers concealed on my person. Having satisfied them that I had no secret pockets in my skin, they handed me back my clothes, but before I could resume them, the two women travellers were turned out of the adjoining compartment. There was no separate exit, and I felt embarrassed.

By the time I was dressed, the sergeant appeared from the other shed and informed me that I could not pass with that paper. I must go back to Antwerp and get a proper passport from the Kommandantur. Protestations were useless; he could or would not understand my arguments, and walked off, leaving me in a state of despair. Then the other sergeant appeared and addressed me in excellent English, strongly flavoured with an American accent. He explained that he had spent ten years of his life in the States, and admired the Americans immensely. He hinted that it might be possible to pass me through, and told me to go back to the village and wait for him in a certain "estaminet." He would come and chat to me about America when the Herr Lieutenant had departed. I found the "estaminet," and, after waiting half an hour, he arrived. He explained to me how, in company with a hundred other reservist officers he had been recalled to Germany some two months before the war, and incidentally stated that on his arrival he was sent to Antwerp, a business house in Antwerp, with special instructions, and only recrossed the frontier two days before the outbreak of the war with Belgium. Then he asked me if I was willing to give a little contribution to the hard worked soldiers. I answered that I was willing, within reason, and the sum was fixed at 30 francs. Then he explained that, although it was impossible to pass me through the post on account of the other sergeant, whose conscience was more expensive, he would direct me to a "braconnier" (poacher) who would for a small sum show me the way under the wire. He himself would meet me on the other side and return me my paper properly "gepruft," without which I could not pass the Dutch frontier. As a guarantee of his good faith he agreed that I should withhold the contribution until I was on the other side of the wire.

By this time it had become quite dark, and my tame sergeant told me it was time to start. He was good enough to conduct me down the road until we came to a clariere, or pathway through the trees. Here he gave me instructions to walk on till I came to a cottage, and then he said "au revoir" and left me to find my way. It was pitch dark, and I stumbled through the "clariere" for nearly two kilometres before I came to that cottage. In answer to my knock the door was opened by the longest specimen of humanity I have ever seen. The door was nearly the average height, but the lintel hid from my view his head and neck.

I explained in indifferent Flemish that I needed his help to pass the barbed wire that night, and for answer he held out his hand. Knowing the Belgian partiality for shaking hands, I wrung his most cordially, but I found that I had mistaken his motive when he continued to hold out his hand and mentioned "teen franken." When I had paid him his ten francs he asked me to come inside and wait, as he would not be starting for quite another hour. He told me that a party of 17 Belgian recruits were attempting the passage tnat night. I was not pleased with the news, as I anticipated difficulty with my sergeant on the other side if I arrived in company. However, he explained that they were not going "en masse," but were divided into groups of four, each group being led by a different guide. For his share, he was only taking one other besides myself, and that other was an experienced wire crawler. Then he went out and left me in the cottage.

At the end of an hour he returned with my fellow passenger, a thin and wierdly shaped youth from Ant-

werp. I afterwards learned that the bulges on his person were due to innumerable packages and letters. He departed and returned three times a week with this forbidden correspondence, and reaped an abundant harvest in fees from the senders. The "braconnier" had strapped on his back an empty petrol tin. I inquired the reason of it, and he explained that if we were in danger of discovery we were to hide in the bushes whilst he went forward and showed himself. Now, the export of petrol from Holland is strictly forbidden, and, as the Germans are very short of it, they connive at the smuggling of even small quantities, and are only too glad to aid the smugglers.

It was bright moonlight when we started out, and was beginning to freeze. We followed our guide for about five kilometres through innumerable copses and plantations, always avoiding the open spaces and high roads. Presently we came to a banked-up road which crossed our path, and on the other side we could see the moonlight glistening on the field of barbed wire.

Here our guide went forward and told us to hide in the undergrowth until his return. He instructed me to remove my overcoat and tie it over my head so as to hide my face and also to protect my neck from scratches when passing under the wire. He also instructed us to tuck the ends of our trousers into our boots, as we should have to wade through a marsh which was notorious for its leeches. A truly pleasant prospect!

He disappeared over the bank, but in a few minutes was back again telling us to lie flat and keep quiet. His reason was soon apparent. Along the road came a patrol of soldiers. We could hear them some distance away as they were making an appalling noise with their heavy boots. Probably "parade marching" to keep their feet warm. When they were nearly opposite us their attention was attracted by a distant rifle shot followed by a small volley. They halted to listen only five yards from where we were crouching in the grass, and we hardly dared to breathe. Presently their officer gave them an order, and they started off again at a quick pace, making more noise than ever.

They were hardly out of sight before our guide signed to us to follow him, and we crawled quickly over the road and dropped into the marsh on the other side. The water was icy cold and in some places above our knees, but we had to wade through it for some distance before we reached the high ground in the centre where the wire crossed the marsh. Here, thanks to our guide's previous experience, we found a place where the level of the wire was raised eighteen inches above the ground, and we wriggled under it, flat on our stomachs. Even then I felt an occasional hook ripping into my clothes, and my gloves were in tatters when we arrived on the other side.

The guide having pointed out the road, we bade each other good-night and separated. I walked across the fields to a point where I could see the main road shining in the moonlight, and as I dropped over the fence into the road, a figure stepped out of the shadow and challenged me. Fortunately it was my sergeant, and after an exchange of compliments, and other trifles, I started on my way to the frontier post. There, on production of my "gepruft" document I was allowed to pass into Holland without further trouble.

From there I had a further four kilometres to walk to H—, where I found a tram to Bergen-op-Zoom, and from there I took the train to Breda, arriving there about 11 o'clock. Only when I was in bed did I realise that I was very tired, and had been travelling since 3 o'clock in the morning, and mainly on foot, and during the last part of my journey my trousers had frozen stiff. Next morning I learned that the rifle shots which had distracted the patrol's attention were fired at some of the other fugitives who had attempted the passage higher up. Unfortunately three of them were killed. I am wondering what my friendly sergeant would say if it should ever come to his knowledge that he materially helped in the evasion from Brussels of an Englishman (Gott Strafe im), and one who had been keenly sought after by the Kommandantur for some months before his departure.

Police Court Proceedings by Extern.

WHILST attending a case recently on the District, one of our Externs had the misfortune to have his bicycle stolen by a passing thief, and this in spite of the fact that he had carried it inside the Buildings which he was visiting, so that it should be out of harm's way. Great was the indignation of the Borough ladies when the theft was discovered and many the vows of a ferocious punishment if they ever laid hands on the delinquent!

However, the new owner of the bicycle was traced to Whitechapel, and arrested whilst trying to dispose of it. At the police court, "five months with hard labour" was the sentence passed by the magistrate.

One incident in the trial may be of interest to our readers:—

Prisoner (interrogating Extern, who is in the witness box): Did you see me taking the bicycle?

Extern (with fervour): No! and it is a jolly good job for you that I didn't.

Gazette Special Pathologist.

T. M. J., CHEADLE.—This sputum contains a little muco-pus, but tubercle bacilli are not detected.

PATHOLOGIST.

Asthma in Childhood.

CLINICAL LECTURE BY Dr. CAMERON.

Gentlemen,—In the present lecture I wish to lay stress upon some peculiar features of asthma in childhood as well as upon some of the special difficulties which its diagnosis at an early age presents. I shall take it for granted that you are familiar with the clinical picture of spasmodic asthma as it occurs in adults—the sudden paroxysm or series of paroxysms, recurrent and often periodic, which begin suddenly, most often in the night, and rapidly reach great intensity, which are accompanied by loud wheezing and by a marked difficulty and prolongation of the *expiratory* movements, so that the lungs are distended to the maximum. Such a paroxysm seldom lasts for less than a few hours, and then terminates somewhat less suddenly than it began. It is not necessarily attended by cough or expectoration, but is usually followed by some signs of increased bronchial secretion. There is no fever, and the attacks are not dependent upon any constant organic lesion, are never the direct cause of death, however severe and alarming, and are compatible with good health in the intervals between them.

I shall not stop to emphasize what is well known to you, that asthma is a respiratory neurosis, which depends upon some disturbance of the nervous mechanism of respiration, and that auto-suggestion plays a great part both in the production and in the relief of the paroxysm.

Often individual patients will demonstrate that their attacks are dependent upon the most trifling changes in their surroundings. A patient who is free from attacks when sleeping in one room will suffer severely if he passes the night in another in the same house. The presence of a cat in the room, even momentarily, the smell of certain flowers, the smallest indulgence in this or that article of diet will provoke an attack with absolute certainty. Such a liability is to be explained only by the caprice of a powerful auto-suggestion acting upon the mind of the patient. In the same way absolute relief is often found in the most bizarre remedies. Let the patient believe in the efficacy of the remedy and the remedy is thereby endowed with power to cure. Patent medicines, with their most encouraging advertisements, are apt to find in asthma their finest field and achieve their most striking results. On the other hand, in cases in which the neurotic element is not apparent, the attacks can often be checked by a powerful exercise of will power.

In children we find a very different clinical picture. It is estimated that about 40 per cent. of cases of asthma begin before the tenth year, but I think that many pass unrecognised. It would be strange if a functional neurosis such as asthma were not often met with in childhood, when nearly all other neuroses have their maximum frequency. The emotions of young children are little under control, and fits of uncontrollable laughter and crying which would be called hysterical in later life are so common as to pass without comment. Chorea, enuresis, habit spasms, sleep-walking, stammering and convulsions are every day matters with sick children but rare and ominous in adult life.

In children, asthmatic attacks are apt to pass unnoticed, because it is characteristic of the ailment at this age that the accompanying bronchitic symptoms are much more prominent than in adult life. The younger the child the more marked is this bronchitic component in the attack, and its essentially asthmatic nature may not be recognized. Indeed by physical signs and symptoms alone it may be doubted whether it is possible to distinguish from among the huge number of cases of infantile bronchitis the comparatively small group in which asthma is present, and which may later in life manifest itself as typical spasmodic asthma.

Further enquiries in three different directions may arouse our suspicions. We should enquire into the family history, we should enquire into the history of previous ailments in the child, and we should make a differential count of the leucocytes of the blood.

(*a*) *The family history.*—Most though not all children who develope asthma in early life come of an asthmatic stock. Sometimes instead of asthma a history of hay fever in the family is obtained, and generally speaking asthma and hay fever develope together, sometimes one affection and sometimes the other appearing in the family tree. Trousseau believed that there was a close relation between asthma and gout. Several of my patients have come of a family in which migraine was common.

(*b*) *The history of previous ailments in the child.*—I leave on one side the difficult question of diathesis in childhood. That peculiar predisposition to disease which French authors call neuroarthritismus, which Czerny terms

the exudative diathesis, and others speak of as status lymphaticus, or lymphatism, plays here a great part. To define clearly all the interesting speculations which hang around this conception of an inherited vulnerability of the mucous membranes and of the skin to irritants and catarrhs of all sorts, accompanied by an enlargement of all the lymphatic apparatus of the body secondary to this constant irritation, is not possible in a single lecture. I must confine myself to calling your attention to the frequency with which eczema, seborrhœic eczema and urticaria is met with in the history of children suffering from asthma.

In my own experience at least half of the children who present themselves with asthma have suffered from eczema at some time or another. Severe attacks of urticaria, giant urticaria, or even, as probably in Case 4, mentioned below, angeioneurotic œdema are not infrequent. Further, many of the children show adenoid vegetations and enlarged tonsils, whether alone or as part of a general hypertrophy of the lymphatic system. Children who show these symptoms are apt to prove dangerous subjects for anæsthesia. In a case of status lymphaticus which had succumbed under an anæsthetic, given for the removal of tonsils and adenoid vegetations, and which was very fully studied and reported recently to the Section of Anæsthetics of the Royal Society of Medicine, the presence of intractable eczema in infancy was noted in the clinical history. Similarly, in such children it is well to bear in mind that the injection of antidiphtheritic or other serum may give rise to pronounced anorphylactic phenomena, which in some cases have proved fatal. The asthmatic child is often anæmic, excitable or definitely neuropathic.

(*c*) *The differential leucocyte count.*.—An increase of the eosinophil cells of the blood, which is not infrequently found in adult asthmatics, is both more common and of greater intensity in childhood. Ten to fifteen per cent. of eosinophil cells may not infrequently be found.

If our enquiries into these three points prove suggestive it will be well to suspect the presence of incipient asthma in the bronchitic child and to watch the attacks carefully with this in mind.

I have written below the histories of the last four cases of asthma with which I have come in contact, and they illustrate the points well.

CASE 1.—At present in Addison Ward. P. L., a boy, æt 11. Sent from a Tuberculin Dispensary with the suggestion that his spasmodic attacks of dyspnœa might be dependent upon the pressure of deep-seated tuberculous glands. His mother herself thought that he had had asthma since he was 10 months old. Her own father had suffered severely all his life from asthma, and she was very familiar with the appearance of a paroxysm. Further, her husband, the father of P. L., also suffered from asthma, but the attacks only came at long intervals, sometimes only once a year. In the case of P. L. there had been repeated attacks of bronchitis during childhood. At first, his mother said, these were pyrexial, but when the boy was about six years old their character changed and they became like those of her husband and father. He had several times suffered frem urticaria, for which he had attended hospital. He had never had eczema. The attacks of dyspnœa were becoming much more frequent. She thought that excitement of any sort always produced them, and that they had been worse since he was attending the Tuberculin Dispensary. In Addison Ward no attack of any severity was seen, perhaps because he appreciated our anxiety to witness one. Similarly a patient with persistent enuresis at home will hardly ever show any sign of his complaint when admitted to hospital for observation. He was a thin boy, small for his age. There was no evidence of adenoid or glandular enlargement. He was keenly interested in his condition, but not neurotic or excitable. Treatment for ring-worm with x-rays had rendered him nearly bald on one side of his head. Auscultation of heart and lungs showed no signs of disease. A von Pirquet test was negative.

The differential count by Dr. Nicholson is typical:—

Hæmoglobin	...	100
Red blood corpuscles ...		5,420,000
Leucocytes	...	7,600
Colour index	...	·9
Polymorphonuclears ...	24·2	per cent.
Eosinophils ...	*11·6*	„
Lymphocytes	57·8	„
Hyalines	5·0	„
Basophils	1·4	„

500 cells counted. One coarsely stippled erythrocyte.

CASE 2.—Seen July 21st. H. H. E., a boy, aged 8. The child was very large and obese. His weight was 6 st. 12 lbs. The average weight for his age is 3 st. 12 lbs. He was sent

to me by Mr. Ormond, who is treating him for "spring catarrh," a recurrent severe conjunctivitis from which he suffers every spring. The conjunctiva is reddened with numerous granulations. On his cheeks and on the point of his chin there is a reddening and infiltration of the skin with dry chronic eczema. His cheeks "chap" readily in the wind. On his body, at at the time of examination, were four urticarial blebs, and from these he suffers frequently. He is subject to monthly bilious attacks, which are probably due to migraine, and from infancy onwards has had severe bronchial attacks. The slightest cold "goes to his chest," and produces embarassed breathing, which is called by his mother "croup." She herself has all her life suffered from typical migraine and from spasmodic asthma, which comes on in severe attacks at night and lasts some hours. Although so obese and unwieldy, the boy is active and intelligent. It is possible that he suffers from so-called "status lymphaticus" and asthma. A blood count has not yet been made.

CASE 3.—J. P., a boy, aged 4 years. Seen first when aged six months in April, 1911, for very acute seborrhœic eczema. The whole scalp and face were covered with caked, waxy, yellowish exudate. The body had refused to thrive on the breast and had been fed with Allen & Hanbury's Foods. In two months the seborrhœa had disappeared under treatment with an ointment containing sulphur and salicylic acid. Seen again in June of this year for repeated asthmatic attacks, from which two maternal aunts also suffer.

CASE 4.—M. C-S., a girl, aged 3. Seen in May of this year. In the first two years of life the health had been absolutely good. Her maternal grandfather, one maternal aunt, and one cousin suffer from asthma. In the last year she had had three attacks of acute dyspnœa. In the last of these there was such great distress that it was discussed whether tracheotomy might not be necessary. Her doctor remained with her all night, but the attack passed off almost as quickly as it had begun. During all this year she had at times suffered from giant urticaria for which Sir Cooper Perry had been consulted. No blood count has been made but the attacks are probably asthmatic, although the severity of the last seizure certainly suggests the possibility of angeioneurotic œdema of the glottis, associated with the giant urticaria.

I do not know that if I were to search through a much larger series of cases of asthma in children that I should find the points which we are considering—the asthmatic family history, the eczema, and the urticaria—equally well marked, but their presence has been noted by many observers.

Apart from its close association with bronchitis and the admixture of the purely asthmatic symptoms with those of bronchitis, the differential diagnosis of asthma does not present great difficulty. Although I have occasionally found an asthmatic child admitted to the Diphtheria Ward with the suggestion that it is suffering from laryngeal diphtheria, it is not usually difficult to distinguish the two affections. In laryngitis the obstruction is mainly to inspiration, and inspiratory recission of the chest is marked. In asthma the obstruction is to expiration, the chest is fixed and overdistended, and the respiration may be distinctly slower than normal, because of the long laboured expiration. It is important not to confuse the two conditions, and to needlessly inject serum because of its danger to asthmatics. Laryngospasm is found only in infants with other symptoms of spasmophilia, convulsions, facial irritability, tetany, etc. Pressure upon the trachea from tuberculous mediastinal glands may simulate asthma closely, and you will remember that this diagnosis was suggested in the case of P. L. In such cases, however, the breathing is more stridulous, and a paroxysmal cough like that of whooping-cough is common. Constant pyrexia, enlarged veins on the chest, and a severe and progressive illness would establish the diagnosis of tuberculous glands; eosinophilia that of asthma. In uræmia in children severe attacks of breathlessness like those of asthma are not uncommon, but the breathing is then exaggerated and hyperpnœic rather than dyspnœic, and the respiration has a peculiar hissing sound. The urinary examination will establish the diagnosis. Hysterical breathing is not common in young children. In adults it is to be recognised by its cessation whenever the patient talks, and by the reversed rhythm of respiration, the pause following the inspiratory, not the expiratory movement.

The treatment of asthma is both prophylactic and symptomatic. Under the former heading the psychical treatment of the child is the most important. Hypnotic suggestion will no doubt often achieve striking results, but it is not wise to resort to this until other methods have failed. An asthmatic paroxysm is so distressing a thing to witness, that the parents must first be reassured. It must be explained to them that however ill the child may appear

to be, he is not in reality suffering from any serious organic disease. They should be encouraged, at any rate in the presence of the child, to treat the paroxysm as of little moment, about which there is no need to make a fuss. The child should no doubt be under medical advice, but his visits to the doctor should take place between the attacks, and unless the distress is very great, the doctor need not be summoned in haste at the onset of a spasm. Separation from too anxious parents may be necessary.

The child's diet should be carefully supervised, and if attacks are frequent the amount of food should be kept at a very low level. Grown-up asthmatics learn to be very abstemious in the matter of food, and especially avoid a full meal in the evening. The chief meals of the day should be at breakfast and in the middle of the day, and the evening meal should be of the lightest. Asthma, like another respiratory neurosis—whooping-cough, and like enuresis, is especially prone to occur at night, when the nervous control is lowest. Eggs and milk are said to be badly borne by many asthmatics, and the diet may with advantage consist largely of vegetable and cereal foods and of fruit. Meat should only be taken once a day, and constipation should be prevented by a free use of a good table-water.

If adenoid vegetations are large and are obstructing the free inlet of air, they must be removed.

Lastly, the freest and most vigorous open air life is essential, and every attempt must be made to promote the physical development of the child. Small doses of potassium iodide are credited with the power of holding off the attacks.

During an attack at night the room should be brilliantly lighted, and the child may be encouraged to get out of bed and, if possible, interest himself in books or toys. In some children the mere turning on of the light will control the attack. Chloral is, I think, the most useful drug to administer, but atropin or belladonna are also effective. In some cases the act of vomiting seems to stop the attack, and we may try to produce emesis by tickling the fauces or by administering an emetic. A hot bath is a simple remedy which does not excite the child and will often be quite sufficient. In the bronchial asthma of very young children, the attack, which is often pyrexial, is likely to be of longer duration and must be treated by confinement to one room, the steam kettle, counter irritation and the usual remedies for bronchitis.

Nursing News.

MATRON'S OFFICE,
July, 1915.

From ——, at Millicent Sutherland Ambulance, c/o M. Duriez, Bourburg, France, Nord.

"I expect you know we were shelled out of Dunkirk; had to evacuate all our patients just when we were desperately busy. It was no good stopping, as no more patients were brought there, and now the place is quite deserted. I do wish you could see the camp here, its just delightful; and we had the greatest fun putting it up. I have got a dear little theatre and a splendid X-ray tent, all lined with red, which makes it look rather like a fortune-teller's. We were terrified the X-ray wouldn't work, as we put it up ourselves, and it *was* a relief when it went most beautifully. The camp is electric lighted, and ever so comfortable. A lot of us sleep out at nights, as we have had glorious weather.

"There are six big tents, each with 20 patients; we are not full at present, as there is very little doing on the French line.

"I am so glad the French Flag '3' have joined up and are coming out again; that was a hopeless scheme, for all the 'British Journal' may say.

"Sister Bartlett has had to go home as her mother is ill; we are so sorry; she left suddenly yesterday. S. Ford is still here, and, of course, Mr. Morgan, and a surgeon who was at the first hospital that I went to in Dunkirk. Four Sisters from there also joined here. so it was awfully nice for me.

"All the French officials are awfully complimentary about the camp, but they always are struck with the English hospitals, and so they ought to be!

"We get the wounded direct from the front; the train comes through Dunkirk, and is stopped here instead. It was just horrid coming south when we had talked so much of going north, but Dunkirk was untenable. I shall never forget that last day of the bombardment and the awful noise of the shells. I came down here in a French transport, sitting on top of my precious X-ray cases."

From Miss Tyler-Cove:—

"Miss Tyndale and I are now on day duty again, and are not sorry, although we were quite happy while we were on night, the only drawbacks being—I. The heat. It was so difficult to sleep in the daytime owing to that, and the flies, which were dreadful! II.—(a) The noise. The recreation tent was just at the back of ours, and the men would play—or try to play—the piano all day long. (b) French defaulters were made to bugle and play drums for hours on a stretch just close to this camp. We all thought that other people were punished more than the defaulters. It is a quaint idea of punishment, and to choose a position

just beside three or four hospitals! Perhaps they thought it cheered the patients!

"Miss Tyndale and I were, for once, in luck's way, for we were very slack when we came off night, and so got a sleeping day off and another the next day. We made the most of that day.

"We started off early and caught the 10.15 a.m. boat and went down the river to a village where there is supposed to be an old ruined castle. I say "supposed" because we could not get anywhere near it for barbed wire, and one is supposed to be able to see over it.

"The scenery on the banks of the river as we went down was perfectly lovely. I cannot describe it, because I am no good at that sort of thing, but it was as if nature had made up her mind to make the place as beautiful as it was in her power to make it. Wild flowers, rushes, shrubs of every description ran riot along the banks, and in the distance hills covered with forests; every imaginable shade of green seemed to be there.

"When we got to the village we had lunch at an hotel on the banks of the river. We sat by a huge window with a gorgeous view down the bend of the river. After that we started off to see the Castle, which we could not get near. It was a lovely country road, with woods on each side most of the way and all sorts of wild flowers, which we picked and brought back for the wards. There were also wild strawberries in profusion.

"On the way, on the top of a hill, was a memorial set up to the soldiers from that part of the country who had given their lives in battle in 1870—1871. There was a figure of a French Tommy, with all his equipment on, most beautifully sculptured. It was quite life-like in attitude.

"We enjoyed that walk though we did not see the Castle, and got back to the quay just in time to meet Miss Foxon who had come down by the afternoon boat. We all went back together, and got back to camp feeling very well satisfied with our day.

"I hope you will not be bored with all this, but I thought you would like to know the sort of things we can do when we are slack enough to have days off. We are still very slack, though I should not think we should remain so for long. We shall probably be so busy we shall not know how to get things done.

"We were frightfully busy when we first went on night duty. I was over on the medical side, and out of the 270 beds I had in my charge only ten were not occupied, and the ones in were mostly bad *surgical* cases, and some a mixture of medical and surgical. There were only myself and one nursing orderly and one G.D.O. to run the whole side. Those were busy times. Fortunately there is a hut where all the most serious cases are put, but even then there were a good many bad ones in the tent. I do not like having bad ones in the tents, they always seem so far away, and one never knows what is happening to those in a tent at one end of a line while you are in a tent at the extreme end of another line.

"That very busy time did not last very long, fortunately. Miss Tyndale was frightfully busy then, too. She was running two surgical huts with the most serious cases in from that side. It was like running 'Astley' and 'Corney' with half a Pro., as she had one G.D.O. who was most desperately slow. Luckily he was most reliable, which made up for a great deal.

"Just at that time five Canadian Sisters were sent here, so one of them was put into the large surgical hut on night duty, and so things were easier. Of course, as soon as they arrived we got moderately slack. That always does happen. We have had two more Canadian Sisters sent here, so now we have seven. They are very jolly, good-natured women, but oh, their voices!

"Miss Tyndale has gone over to the medical side now on day, and I am on the surgical. I have a line of four marquees and only seven beds in each, very different from night duty. Miss Tyndale has five or six marquees, I am not sure which, with eight beds in each.

"The weather is frightfully hot at present and this race course has absolutely no shade at all except at the extreme edge where we do not work. Sometimes working in this extreme heat is appalling.

"Miss Foxon is still in the Theatre Hut on day duty. Its an awfully nice ward she has there, with only eighteen beds, but plenty of work when they are busy. The Theatre Hut has the Theatre, as its name implies, and a regular sister is in charge of that and the ward. A Canadian Sister is in the ward with Miss Foxon."

Address, c/o The Principal Matron, Q.A.I.M.N.S.,
Tigne Hospital,
Malta,
8th July, 1915.

Dear Matron,

"I have been a long time writing to you, but we are very comfortably settled down now. Fifteen Sisters, including Sister Bott and myself, were sent over here three days after our arrival to open up this new hospital; an hour and a half after we got here about 150 wounded arrived, but no stretcher cases, so we had a busy time.

"The hospital was a barracks, but has only been built a few years; there are four blocks of 144 beds each, and about 30 officers in the officers' mess. We keep getting more sisters and have over 30 now, including four of the First Serbian Unit, who have stopped for a month on their way home. Sister Bott is Home Sister and assists Matron generally, and I am Theatre Sister.

"I have got the dearest little theatre; two rooms, with nice tiled floors, and most beautifully got up and

really well equipped. I quite enjoyed getting everything ready.

"We are just beginning to get busy, as the situation here is so healthy, with the sea on both sides of us, that the authorities have decided to send us the worst cases.

"We get excellent off-duty time, the same as in England, except, of course, when we are taking-in. I have been most lucky in seeing my sister, as the *Somali* was in the day we arrived, and we went to dinner on board that night. She has just been in for the second time and some of our wounded came off her. They have very exciting times and have been right up to Cape Hilles and seen the fighting. Our Matron, Miss Stevens, was in charge of the *Asturias* for eight months; we were all very sorry not to see any of them on board, as she put in here for a few hours one day this week.

"Sister Bott and I are both very well and enjoying our work here immensely. We do not seem to feel the heat much, but, of course, the hottest month is still to come. We bathe every day and sleep out on an open verandah.

"With kind regards, in which Sister Bott joins me,

I remain, yours sincerely,

G. MILDRED FRANK.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR,—You were kind enough to print a letter from me asking for comforts for No. 22 General Hospital in France, in response to which appeal I have received many gifts in money and kind, which will be greatly appreciated by the Guy's Sisters for their patients.

I heard last night that No. 22 Hospital has been taken over by an American unit at a few hours' notice. The majority of Guy's Sisters have been transferred to No. 26 General in the same part of France "in huts, such nice wards, and the theatres really beautiful. There are over 50 Guy's here now."

Under these circumstances I am sending all gifts to No. 26 and will continue to collect for it. Please accept my best thanks for your kind help.—Yours faithfully,

L. V. HAUGHTON,
Matron.

Matron's Office,
Guy's Hospital,
July 27th, 1915.

SIR,—I was interested to read your discussion on temporary medical work in the Services. Let me offer my own experience as a warning to those who hope to serve their country professionally by joining the Navy. I have now been at sea for more than six months, and my daily work consists in going to the sick bay at 8.30 p.m. and being informed by the steward that "everything's correct, sir." Perhaps once a week the evening gives me a chest to examine, but I cannot claim to be actively employed on professional work for more than four minutes a day. I believe my time table is a fair sample of those of most temporary surgeons.

To balance this, there are many advantages, and I have thoroughly enjoyed my time at sea. But it is a little humiliating to have a good salary for doing nothing, and a little distressing to reflect that this idleness is stealing away one's all too little experience. "They also serve," of course, but perhaps Milton's angels got a little bored at the end of six months; how much more the "temporaries" who have no claim to any angelic attributes!—Yours faithfully,

H.M.S. *Warrior*. F. GILBERT SCOTT.

DEAR SIR,—I have read with interest a letter describing three cases of cerebro-spinal meningitis in your issue dated May 8th, which has only just reached me, and I should like to inquire in this connection whether treatment with Soamin for this disease has been employed in England with any success.

On my arrival in this country in the latter half of 1913, I found an epidemic of cerebro-spinal meningitis in full swing. It did a great amount of mischief in the Highlands, chiefly amongst Natives, but a good number of white people were attacked as well, and some died.

While I had charge of the Native Hospital at Nairobi, I saw a fair number of cases, though I cannot speak very much about the clinical aspect of the disease, as the cases were sent to an Isolation Hospital as soon as diagnosed, but a large number of dead bodies used to be brought in, and I did a number of autopsies. In practically every case there was injection of the meninges, sometimes purulent meningitis, and almost always a large quantity of blood-stained or even purulent fluid in the ventricles of the brain.

I am not in a position to lay down the law about the treatment, but should advise anyone interested in the disease to read a paper by Drs. Shircore and Ross in the Transactions of the Society of Tropical Medicine and Hygiene, vol. vii., No. 2, for December, 1913; also a paper by Dr. Gilks in the Annual Medical Report for the East Africa Protectorate for 1913. Dr. Shircore had an unusual experience, as he contracted the disease himself after having proved the value of Soamin in native cases, of which he saw a great number. And he ultimately made a good recovery, and is even now back in this service.

It is an interesting fact that anti-meningococcic serum was found to be practically useless, and in view of the success of serum in the three cases mentioned in your issue quoted above, one wonders whether the

failure of serum in this country was purely a question of deterioration due to climate as is suggested by Dr. Ross. The fact remains that its use was entirely abandoned in favour of Soamin in the Nairobi epidemic, and I should be very much interested to know if the latter drug has received a trial in England, as I understand that there have recently been a number of cases in adults. Young adults were the principal sufferers in this country.

Previous to my arrival in East Africa I had regarded cerebro-spinal meningitis as a disease of infants chiefly, and almost always fatal.—I am, Sir, faithfully yours,

GEOFFREY DUNDERDALE,
East African Medical Service.

Lamu,
British East Africa,
25th June, 1915.

DEAR MR. EDITOR,—In the last GAZETTE, by omitting all reference to those recently qualified Guy's men who have been sent to casualty clearing stations and base hospitals, you contrived to give a completely erroneous impression of the amount of active service experienced by those who have taken commissions in the R.A.M.C.

Of the Guy's men who joined the Special Reserve last October, some were assigned to the nuclei of field ambulances in the new divisions. It is true that these men have endured long periods of preparation in this country without any clinical work, but they form a small proportion of the whole number of entries in 1914, and their experience cannot well be repeated.

Those who join in the near future can, I think, confidently expect to be on active service after no unreasonable period of delay, but should they be attached to field ambulances they must expect a longer period of preparation than in the other branches of the service owing to the specialised nature of their duties.—Yours very truly,

J. H. RYFFEL.

27th July, 1915.

DEAR SIR,—The notes in "Passim" of your last issue tend to cast reflection on those men working at the Hospital. As the Staff is generally very closely connected with the War Office and their immediate requirements, we rely on them to inform us in what directions our energies should be employed.

There can never be any question as to Guy's men refusing to do their duty to their country or their Alma Mater. Realising this, the Staff, in the first instance, advised men to make themselves fully efficient. Too many men have rushed off after having obtained the M.R.C.S., L.R.C.P. after their names. This counts for very little, does it not? What does count is the full clinical experience obtained by climbing every rung of the ladder of appointments offered to us at this Hospital, viz., from Clinical to H.-P. or H.-S.

This war is not going to be over in the next few weeks; if it could be, there would still be many wounded requiring all the skill and care we can give them, and the war is not going to stop the various pathological problems which make the Borough so intensely interesting and help the cause of science. In due course the majority of ex-Residents join the naval and military services. It may be hard to be in mufti, but we must remember that we are a profession apart.

If the munition workers in Germany are, at one end, intent on manufacturing various munitions of destruction, we are, at the other, doing our best to repair that destruction. We, sir, we in England and at Guy's fill just as important a part as the man with a regiment in the most advanced trenches, the latter having the glory, a uniform, and a very rough time, and the former uneasiness of mind because we want to be with him, but in reality a clear conscience, no excitement, little credit and less glory.

For goodness sake let there be no recrimination among Guy's men; we hear there is enough among the men abroad as it is. If there are still many Guy's men who cannot decide what is their duty, why, Mr. Editor, do you not ask at the War Office for a letter to your GAZETTE on the subject of the duty of medical men at the present time?

DARE QUAM ACCIPERE.

Reviews, etc.

Diet and Disease in Infancy. By Hector Charles Cameron, M.D., F.R.C.P. (J. & A. Churchill, 1915.)

It has become almost proverbial among the laity that the majority of doctors "know nothing about children," and, if one substitutes the word "infants" for "children," we are inclined to admit that the laity is not far wrong. For infancy and childhood are different states, and, although the average house-officer acquires a very fair notion of the management of the specific fevers, broncho-pneumonia, acute rheumatism, chorea, tubercular disease of bones and joints, and other diseases so common in childhood, it is quite exceptional for him to have the opportunity of getting anything but the most superficial knowledge of many of the disturbances which affect the infant of under two years of age. Most of these disturbances, of course, affect primarily the alimentary system, and are usually traceable either to artificial feeding or to a faulty diet after weaning.

Dr. Cameron's book is, as far as we know, the very first of its kind to appear in England, and we venture to prophesy that much of its contents will open up entirely new ground for thought and speculation among most practitioners, and—dare we say it?—even specialists in this country. The author has an extensive acquaintance with the English, American, and Continental literature on his special subject, and with the important work that has been done of recent years, especially on the Continent.

With this behind him he has studied his own cases, particularly in the light of modern research and theory, and, since he is not less happy in his powers of observation and reasoning than in his facility for vivid description, his book compels our admiration. In

his preface he admits that much of his subject is still very obscure, but, even if some of what he has written proves to be mistaken theory, it is none the less certain that the book fully justifies its publication, and, having said this, we may proceed to consider it in detail.

The introductory chapter emphasises the great dangers of artificial feeding in the first few weeks of life. After three months the adaptability of the infant to different classes of food is usually well established, and it is this remarkable adaptability of the majority which furnishes support for the claims of advocates of certain fixed methods of artificial feeding and of patent food vendors. At the same time, individual idiosyncrasies are met with from time to time, and in this connection is cited the exudative diathesis of Czerny, the victims of which may be unable to tolerate even their mother's milk. A short discussion then follows on the "specific" properties of human milk, which render breast-feeding so eminently desirable. It is pointed out that no amount of juggling with cow's milk will ever humanise it, seeing that its several constituents differ not only in proportion, but in chemical composition.

Some infants may thrive on cow's milk from their earliest days; others entirely fail. The value of colostrum, which confers a passive immunity on the child, is mentioned, and the diminished risk of overfeeding that breast-fed infants enjoy is explained. The secretion of milk and the child's appetite are in close relationship to each other; a hungry child, by vigorous suction, induces a copious flow, whereas a temporary surfeit is followed by a temporary decline in the appetite, and the diminished suction leads to a corresponding diminution in the amount of milk secreted.

The author closes this introductory chapter by pointing out that it is almost impossible to ensure that cow's milk be not contaminated with harmful bacteria, but he also very rightly insists that, while fully admitting that infective enteritis occurs, the majority of cases of diarrhœa and vomiting are not actually due to infection of the bowel itself, but to pathological changes going on in intestinal contents which are themselves abnormal. To such cases the terms "gastro-enteritis" is not strictly applicable.

Chapters II. and III., we learn from the preface, have been written by Dr. Janet Lane-Claypon. They deal with the required standards for a high-grade milk, and the conditions necessary for its production. The subsequent four chapters are concerned with the preparation of cow's milk in the house, the composition and indications for use of certain proprietary foods and milk products, the management of breast nursing, and the evidence of normal digestion.

The following points may be noted. The tendency to too frequent feeding is commented on. It is pointed out that this is often the primary cause of dyspepsia both in breast and artificially fed children. It is essential that the stomach be emptied before a new meal is taken, and with cow's milk, owing to the density of the curd formed, this may take three hours or even longer. The two-hourly interval, so often recommended, is to be condemned, except in special cases; after the early weeks, five or, at most, six meals in the twenty-four hours are usually quite sufficient.

The question of proprietary food preparations is very fairly discussed; they have their uses and, what is more important to realise, their dangers. Their value lies in the fact that they offer as regards their composition a strong contrast to cow's milk; in fact, it may be said that the effects of these two forms of diet are precisely opposite, so that they act as antidotes the one to the other. The high percentage of carbohydrate in patent foods tends to produce excessive fermentation, acid intestinal contents, and diarrhœa; the use of cow's milk, on the other hand, is associated with an alkaline and sometimes formed stool, putrefaction rather than fermentation, and constipation. In those cases in which the diet has long consisted of food rich in carbohydrate and poor in fat and protein, *e.g.*, Nestlé's sweetened condensed milk, a certain morbid condition is produced, characterised by atrophy, which is often masked by œdema; this is well described in a later chapter. It is in such children that a diet of whole milk is so strikingly successful. On the other hand, excessive feeding with cow's milk may produce in certain children atrophy, accompanied by an excessive and dangerous loss of calcium and phosphates by the stools. In such cases proprietary foods may well be given. We would particularly emphasise the fact that to order a whole milk diet indiscriminately is to court disaster in some cases, especially in infants under three months of age; as Dr. Cameron insists, "to fore-tell exactly how an infant will react to an artificial diet is always impossible."

In the chapter on breast-nursing stress is laid on the suction of the child as being the chief, if not the only, stimulus to the flow of milk; anything which prevents proper suction, such as depressed nipples and malformations or disease in the infant, will tend to arrest the flow. The author asserts that lactagogues have no direct effect on the secretion of milk.

The chapters on the classification of the common disorders of nutrition, and the nature of dyspepsia, are, we consider, two of the most important in the book. Simple dyspepsia, intoxication, marasmus, and inanition are contrasted along the lines suggested by Finkelstein, and in later chapters these several morbid conditions are fully considered and characterised. It is impossible and unnecessary in a review such as this to enter into any detailed account of the views set forth, but a more logical and convincing account of infantile dyspepsia, and the acute and chronic disturbances that may result therefrom could hardly be desired. We may, perhaps, refer briefly to one or two points of especial interest.

The classification of dyspepsia into three main groups —(1) ex alimentatione, (2) ex infectione, and (3) ex constitutione, is of great value. "D. and V." is no diagnosis, and yet it too often suffices in practice, and its treatment is usually purely empirical. We would again insist that the term "gastro-enteritis" has comparatively rarely a pathological basis, the majority of dyspepsias being ex alimentatione and not ex infectione. Even in the severe summer diarrhœas only a certain proportion are associated with actual bacterial infection of the intestine itself. In these cases the infection may be primarily enteral, or part of a general infection (parenteral). Starvation has no effect on the temperature as it has in simple dyspepsia, and blood may be passed in the stools.

We have already briefly referred to the cases of chronic malnutrition produced either by overfeeding with carbohydrate or cow's milk. The subject is of great interest and importance. Instances of so-called "carbohydrate œdema" are met with in the first group. In an article by Dr. David Curle in the *Practitioner*

some time ago this condition was described in connection with rickets, whereas, according to Dr. Cameron, pronounced rachitic symptoms are not common in these cases. In cow-milk atrophy, on the other hand, rickets is said to be a common complication, the explanation given being that the stools of these children contain large quantities of calcium combined with fatty acids to form soaps (the soapy masses have long been erroneously described as "casein curds"), and that this depletion of the body of calcium produces the disease.

The chapter on rickets itself may well be considered here. The exact causation of this disorder has, of course, long been a vexed question. The view most generally expressed is that lack of fat and protein in the diet, together with faulty hygiene in its widest sense, forms the chief predisposing cause. On the other hand, as has been mentioned, excessive cow-milk feeding is also thought to be capable of producing the same disease. In other words, a diet rich in carbohydrate, but deficient in fat and protein, and one rich in the latter constituents, but poor in the former, may lead to the same result. The view that a cow-milk diet acts by causing an abnormal excretion of calcium and phosphates is attractive, but it does not explain those very common cases of rickets which would appear to be associated with a lack rather than excess of milk.

It seems to us probable that when our knowledge of the bacterial flora of the intestines is more complete the problem of this disease may be solved. It is, perhaps, unlikely that, as Mircoli has suggested, the bony changes in rickets are of the nature of a chronic osteomyelitis, but it is conceivable that abnormal intestinal organisms may, by interfering with proper digestion and absorption, be at the root of the evil.

Dr. Cameron has given us excellent accounts of "spasmophilia" and the "exudative diathesis." The former comprises symptoms, such as tetany, laryngospasm, and convulsions, which in English text-books are commonly described as complications of rickets. Both conditions are ascribed to calcium deficiency, which affects, in the one case, the osseous, in the other, the nervous system. With regard to the exudative diathesis, which corresponds more or less to the scrofulous diathesis of older authors, we are glad to observe that the ancient conception of morbid diathesis shows signs of re-asserting itself. We may not understand their causation any more than we know why one person is bad-tempered, another phlegmatic, but to deny their existence is to shut one's eyes to what is only too apparent. The short chapter on the neuropathic infant is also excellent.

There are many other interesting points in the book which well merit notice and discussion. We will content ourselves, however, in commending it to the notice of every medical man, as well as others who are concerned with the management of infants. As examples of the author's gift for graphic writing we may cite his description of alimentary intoxication and the chapter on inanition. Finally, it should be remarked that the suggestions for treatment are clear and logical, and the value of the work is greatly enhanced by some excellent plates of the normal and abnormal stools, and by accounts of illustrative cases, with several speaking charts. We congratulate Dr. Cameron on his book, which will ensure that anything he may choose to write in the future will certainly command attention.

Appointments.

Civil.

D. R. T. Griffiths, L.S.A., L.M.S.S.A. Lond., has been appointed Certifying Surgeon under the Factory and Workshops Act for the New Quay District of the County of Cardigan.

C. J. Lamb, L.D.S., R.C.S. Eng., has been appointed Dental Surgeon to the Scattered Homes by the St. Germans (Cornwall) Board of Guardians.

Naval.

Fleet Surg. L. Bidwell, R.N. (retired), to the *Marmora*.

Staff-Surg. F. C. Robinson to the *Vivid*, additional for disposal.

Staff-Surg. H. R. H. Denny to the *Royalist*.

Surg. G. F. Syms to the *Vivid*, additional for disposal.

Surg. K. H. Hole, M.B., to the *Victory*.

Surg. G. F. Syms to Wormwood Scrubbs Air Station.

Surg. A. E. P. Cheesman to the *Pembroke*.

Staff-Surg. C. H. Dawe and Surgeon R. A. Rankine to the *Pembroke*, additional for disposal.

Surg. K. H. Hole to the *Thames*.

Surg. T. Turner, R.N.V.R., to Wormwood Scrubbs Air Station.

Staff-Surg. C. H. Dawe to the *Stonewall Jackson*.

Staff-Surg. F. C. Robinson to the *General Grant*.

Surg. C. G. Sprague to the *Pembroke*, additional for disposal, to the *Dahlia*.

Surg. G. B. Cockrem to the *Vivid*, additional for disposal.

Surg. H. E. Perkins to the *Pembroke*, additional for disposal.

To be temporary Surg.: G. S. B. Long.

Royal Army Medical Corps.

Capt. H. V. Leigh, 5th Welsh Regiment, has been transferred to the R.A.M.C., and is now serving with the 22nd General Hospital.

A. de Winter Baker has been appointed Resident Anæsthetist to the County of London War Hospital, Epsom.

To be temporary Captain.—E. H. Starling.

To be temporary Lieutenants.—J. E. Hodson, H. W. Drew, Angus Wylie, E. F. Clowes, W. J. D. Smyth, S. Hodgson, A. M. Roome, E. W. Goble, H. G. Dresing, E. Faulks, R. Fell.

5th London Field Ambulance, Lieut. P. S. Price to be temporary Captain.

1st London Casualty Clearing Station, Capt. John W. Kemp to be temporary Major.

The undermentioned Captains to be Majors.—F. J. Steward, C. H. Fagge.

H. F. Lancaster to be Captain, whose services will be available on mobilisation.

2nd East Anglian Field Ambulance, Arthur Green to be Lieutenant.

3/6th London Field Ambulance, Lieut. P. Seymour Price to be Captain.

To be Army Dentists with the rank of Lieutenant.—J. M. Barnes, R. M. King.

Roll of Honour.

2nd Lieutenant W. A. Stanwell, 2nd Lancs. Fusiliers, killed in action.

Change of Address.

Lieut. P. W. L. Camps, R.A.M.C., St. Julians Hospital, Iliema, Malta.

Lieut. E. J. Cooke, R.A.M.C., Milton Hill Hospital, Steventon, Berks.

Lieut. C. Worster-Drought, R.A.M.C. Mess, Woolwich, S.E.

Surg. G. W. King, Haulbowline, Queenstown, Ireland,

Harold Gardiner, M.S., F.R.C.S., 72, Wimpole Street, W. (Tel. Mayfair 3407).

Lieut. J. L. Perceval, R.A.M.C. (S.R.), 59th Field Ambulance, 19th Division, British Exped. Force, France.

Lieut. T. A. Townsend, R.A.M.C., Officer's Mess, 2/1st London Field Ambulance, 49, Crown Street, Bury St. Edmunds.

Surgeon H. C. Mann, M.D., M.R.C.P., R.N., from R.N. Hospital, Plymouth, to H.M.S. *Duncan*, c/o G.P.O., London.

W. Shirley Kidd, M.B., B.S , from 54, Leeds Road, Harrogate, to 22, York Place, Harrogate.

Papers by Guy's Men.

Staff-Surg. R. W. B. Hall, R.N.: An epidemic of influenza in the Island of St. Kilda.—*J. of Roy. Naval Med. Service*, July, 1915.

Fleet-Surg. A. R. Bankart, C.V.O., M.B., D.P.H., R.N.: Paint poisoning.—*Ibid.*

Fleet-Surg. C. Marsh Beadnell, R.N.: A buoyant jacket for prevention of death from submersion.—*Ibid.*

A. G. S. Mahomed: Recurrent vesicular rash.—*Brit. Med. Journ.*, July 17th, 1915.

D. W. Samways, M.A., M.D., D.Sc.: Wound dressing.—*Ibid*, July 24th, 1915.

Lieut. H. C. Lucy, R.A.M.C.: British and French salvarsan products.—*Ibid.*

F. N. Doubleday, M.R.C.S., L.R.C.P., L.D.Eng.: On calcification: a restatement.—*Brit. Dent. Journ.*, July 15th, 1915.

E. G. Graham Little, M.D.: (I.) Dermatitis herpetiformis. (II.) Dermatitis herpetiformis in a boy, aged 8. (III.) Chronic septic papilloma which had originated apparently in a bullous eruption.—*Proc. Roy. Soc. Med.*, Dermatological Sect., June, 1915.

W. M. Mollison, M.C., F.R.C.S.: Case for diagnosis.—*Ibid.*, Laryngol Sect.

W. H. Jewell, M.D., B.S.: Halfpenny embedded in Œsophagus.—*Ibid.*

A. F. Hertz, M.D., B.Ch., F.R.C.P.: Paresis and involuntary movements following concussion caused by a high explosive shell.—*Ibid*, Neurological Sect.

T. G. Stevens, M.D., B.S., F.R.C.S.: Specimen of (?) Rhabdomyoma of the vulva.—*Ibid*, Obst. & Gyne. Sect.

W. M. Mollison, M.C., F.R.C.S.: (I.) Microscopic specimen of cells from cerebro-spinal fluid, showing organisms. (II.) Cases of herpes auris. (III.) So-called primary acute mastoiditis. (IV.) Case in which suppuration had performed a radical operation.—*Ibid.*, Otological Sect.

E. W. Ainley Walker, M.D., and others: Demonstration of methods for the isolation and identification of *bacillus typhosus* and allied organisms.—*Ibid*, Pathological Sect.

Births.

KIRKMAN.—On July 17th, at Bangweolo, Staplehurst, Kent, the wife of A. H. B. Kirkman, F.R.C.S. Ed., a daughter.

LANGDON.—On July 25th, at Hillside, North Tawton, N. Devon, the wife of W. M. Langdon, M.R.C.S. Eng., L.R.C.P. Lond., of a daughter.

MAILE.—On July 5th, at 95, Richmond Road, Kingston-on-Thames, the wife of W. C. D. Maile, M.B., B.C. Cantab., a son.

NEVILLE-COX.—On July 21st, at 21, Cornwall Gardens, Brighton, to Dr. and Mrs. Neville-Cox, a son.

PENDRED.—On July 13th, at Crohill, 326, Upper Richmond Road, East Sheen, S.W., the wife of Vaughan Pendred, M.D., F.R.C.S., of a daughter.

Marriages.

HAYCRAFT—HERDSMAN.—On July 9th, at Holy Trinity Church, Penge, Guy Fleetwood Haycraft, M.R.C.S. Eng., L.R.C.P. Lond., Lieut. R.A.M.C. (T.F.) to Dorothy Herdsman, B.A. Lond. Univ., daughter of Mr. and Mrs. Herdsman, of Newlands Park, S.E.

LLOYD—FLOYD.—On July 20th, at Brockmoor, Staffordshire, Frederick George Lloyd, F.R.C.S. Ed., Temporary Surgeon R.N., to Bertha Crispina Floyd, youngest daughter of the Rev. Stephen and Mrs. Floyd.

SYMONDS—POULTON.—On July 7th, at St. Giles' Church, Oxford, Charles Putman Symonds, Lieut. R.A.M.C., to Janet Mary Palmer, youngest daughter of Professor E. B. Poulton, F.R.S., and Mrs. Palmer.

TODD—EDWARDS.—On Wednesday, July 21st, at the Parish Church, Sawston, by the Ven. Archdeacon Westcott, D.D., assisted by the Rev. Lancelot Smith, Alan H. Todd, M.S. Lond., F.R.C.S. Eng., elder son of George Todd, of Torquay, to Constance, younger daughter of the late Dr. Frank Edwards, of Sawston.

Deaths.

CHARTER.—E. J. M. Charter, L.D.S. Eng., eldest son of J. Leach Charter, L.D.S.I., of 1, Pryme Street, Hull, as the result of a motor cycle accident.

FERRABY.—On July 8th, in Edinburgh, Dr. H. P. Ferraby, M.D.

PRYN.—On June 27th, at No. 10, Casualty Clearing Station in France, the result of an accident, William Reginald Pryn, Lieut. R.A.M.C., eldest son of Deputy-Surgeon General W. W. Pryn, Royal Naval Hospital, Gibraltar.

STEVENS.—On July 15th, at Tunbridge Wells, George Jesse Barnabas Stevens, M.R.C.S. Eng., L.R.C.P. Lond., aged 70 years.

E. N. G.

GUY'S HOSPITAL GAZETTE.

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Passim.

LAST Wednesday week was the anniversary of the present war, and it is appropriate in this issue that we should shortly review the past year and the war, as far as it has concerned us in our own small sphere of life.

The first two months—August and September, 1914—saw a large migration of men from the Hospital. Those who were already in Territorial Forces donned their khaki and answered the mobilisation order. Others, who were not already attached to any unit, stepped quietly out of the Hospital gates and presented themselves at a Recruiting Office. Many who had previously done military training joined up at once to their old regiments. Qualified men offered their services at the War Office and Admiralty and were promptly enrolled.

Sisters and nurses also joined the exodus in large numbers and became attached to Queen Alexandra's Imperial Military Nursing Service and its Reserve.

The Staff of the Hospital were not left unaffected, for many became members of the Territorial Forces as Consulting and Visiting Surgeons and Physicians, the majority being attached to No. 2 General Hospital at Chelsea. Since then their duties have increased, and at the present day they give their services at many Home Hospitals.

Men who felt it their duty to stay at the Hospital and qualify, had to work hard and perform the extra duties which fell on their shoulders as the result of a shortage of numbers. Other unqualified men devoted some of their time to acting as dressers on Hospital Ships, whilst others joined the Navy by taking up Surgeon Probationerships—new posts formed by the Admiralty for the purpose of having a medical man on each of the smaller ships of the Line.

Then, on November 1st, Stephen Ward was suddenly emptied of all its civilian patients and within eighteen hours the ward was partitioned off into cubicles, and the first of the many batches of wounded was drafted into the new "Officers' Section."

What a fillip this rapid transformation gave to us all! It was then that we first learnt what modern warfare really was!

Since those first days of the war there has been a continual flow of men and nurses out of the Hospital, all bent on doing their utmost to relieve that pain and suffering which has never before in history been known, caused as it has been, by the deadliest and sometimes the most cowardly inventions of men.

Fifteen Guy's men have given their lives for their country—good fellows and heroes all! We weep for them, but in our grief we hope that the loving pride we feel for them will help us, when our time shall come, to follow their glorious example.

Many of our old friends have been wounded and many mentioned in despatches, two have been awarded the Distinguished Service Order and two the Military Cross.

Only those who have actually seen our wounded soldiers taken into Hospitals and nursed back to health, can speak adequately of the work done by our Sisters and Nurses. They have worked with the cheerfulness and untiring energy, which we at Guy's all know so well, and as one of their patients said, "I cannot find words to express my admiration and gratitude for all that was done for me while I was under their care." One Guy's Sister has had the honour of being awarded the Order of the Royal Red Cross.

Finally, let us consider how the Alma Mater has been faring, whilst so many of her sons and daughters have been away. Many alterations have been made necessary by the shortage of qualified men, but generally speaking work has been "carried on as usual." The duties of each individual worker have certainly been more numerous, nevertheless, they have been performed with a thoroughness which has earned the approbation of the Governors.

So now we must face the second year of the War, and all the burdens and sorrows which must accompany it. But it will only be by making up our minds to do our duty, be it fighting, tending the sick, or making munitions, with all our might, that the blood-red sunset of this last year will be eventually followed by the golden dawn of Victory.

ONE day last week a blood-stained and mud-bespattered Lieutenant (R.A.M.C., Guy's) came up to our Office and asked us if we could give him the addresses of six old Guy's men now serving in France. We were not able to give him more than two of the addresses he required. During the course of our conversation, he told us that, while in France, he was moved to new quarters near Ypres, and that it was not till he had been there over a week, that he discovered that one of his best friends during his hospital life was stationed not a mile away from his quarters. Now, an incident such as the above would have been avoided if all old Guy's men would send us their address whenever it is changed.

We propose to publish with the issue of the GAZETTE of September 11th, the names and, where possible, addresses of all Guy's men serving abroad. It would be a great help to us if all men, who have not seen their names and addresses published in the GAZETTE, would send them to us not later than September 4th for inclusion in this list.

This list would be republished every two months, and any changes of address notified in the intermediate issues of the GAZETTE.

Hypochlorous Acid, as an Antiseptic, has now succeeded Iodine and Picric Acid in the Front and Back Surgeries, and in Patience and Samaritan Wards.

We hope that after a full trial, House Officers and Dressers will send us their opinions of this new antiseptic, as compared with those which have been more extensively used in the past.

THE list of successes at all the recent examinations is a large and very satisfactory one. We have to congratulate Messrs. E. N. Roche, R. C. B. Ledlie and W. R. Spurrell on gaining honours in Inorganic Chemistry, Physics and Biology respectively, in the 1st M.B. (Lond.) Examination. In this examination 22 out of 24 candidates passed, making a 92 per cent. Pass List. In Part I., 2nd M.B. (Lond.), 8 out of 9 passed, making 89 per cent. The results of the Final Conjoint Examination are also highly gratifying.

WE offer our hearty congratulations to Surgeon E. G. Schlesinger, whose name was mentioned in despatches last week.

THE new members of the Resident Staff assumed their duties on August 1st. Mr. S. Wilson (Sir A. Lane's H.S.), Mr. J. F. H. Stallman (Mr. Dunn's, H.S.), Mr. G. L. Attwater (Dr. Shaw's H.P.), Mr. F. Knott (Ophthalmic H.S.), and Mr. A. D. Marston (Junior Charity). Mr. C. Dean continues to be H.P. to Dr. Hale White.

Mr. H. Muir-Smith (Dr. Fawcett's H.P.) and Mr. C. Dean (Dr. Hale White's H.P.) have been elected President and Vice-President for the next three months.

OVERHEARD IN THE LIGHT DEPARTMENT.

A.—"I say, mate, I dunno 'ow ter treat these 'ere nusses!"

B.—"No, mate, nor do I!"

A.—"Yer know, they ain't exactly ladies!"

B.—"No, nor 'ousemaids, neiver!"

A.—"I know what they are—they're broken-down torffs!!!"

A Case of Hæmophilia treated with Intravenous Injections of Calcium Lactate.

F. T. S., aged 59 years, was admitted into Astley Cooper ward under Mr. Dunn on February 28th suffering from hæmaturia, the result of a blow on the right loin which he had received two days previously. He stated that he was a "bleeder," having always bled profusely from any cut ever since he was a child, and having had frequent attacks of epistaxis. About three years ago, he had to be admitted into Cornelius ward for hæmorrhage after the extraction of a tooth. Both his parents were healthy and died at the age of 92 and 93 years respectively, but his mother's father suffered from hæmophilia. He has one brother and two sisters. Neither they nor their children are affected. He has had six children, five of whom are healthy, the other, a daughter, who died from other causes, is stated to have suffered from hæmophilia.

On admission, the patient had profuse hæmaturia, which continued in spite of treatment. He was kept at absolute rest and ice bags applied. On March 12th, 20th, and 29th injections of horse serum were given without result. Calcium lactate given by the mouth was also without effect.

On April 1st, the hæmaturia being still severe, five grains of calcium lactate were given intravenously with no effect. This dose was repeated the following day without result.

On April 6th 10 grains were given intravenously, and by April 8th the amount of hæmorrhage was much diminished. The bleeding gradually increased again till April 13th, when the dose of 10 grains was repeated. In thirty-six hours the urine had become perfectly clear and remained so for two days. The hæmorrhage then returned, and injections were given on April 19th, 23rd, and 26th, each injection being followed by temporary improvement thirty-six hours after. On April 29th the urine was free from blood, but on May 3rd there was again a profuse hæmorrhage. This was again controlled by injection, and the process was repeated on May 10th and 28th. On May 28th, while there was hæmorrhage, the clotting time was taken at 11 a.m. by the method of Dale and Laidlaw, and found to be 1 min. 56 sec. (normal time 1 min. 30 sec. to 1 min. 40 sec.) at 37°C. At 1 p.m. the intravenous injection of calcium lactate was given. At 5.20 p.m. the clotting time was 1 min. 56 sec., but on June 1st, when the urine had become free from blood, the clotting time was 1 min. 35 sec.

From June 1st calcium lactate was given by the mouth three times a day. There was a profuse hæmorrhage on June 2nd, which, however, ceased without further injection. The clotting time taken on June 8th when the urine was nearly clear was 1 min. 30 sec. A few days later the urine was quite clear, and it has remained so ever since, except for a slight hæmorrhage on June 23rd.

Clotting time was 1 min. 50 sec. on June 22nd, and on August 11th, calcium by the mouth having been omitted for ten days, the time was 2 min.

During the period of continued hæmorrhage the patient became very anæmic, the red cell count being on one occasion as low as 1,600,000. His colour is now quite good, and there is no tendency for the hæmorrhage to recur, although he now walks about. No calculus can be seen by X-rays, and the urine is absolutely normal.

The use of intravenous injections of calcium lactate to arrest hæmorrhage was suggested by Prof. Dixon with the idea that by temporarily increasing the free calcium in the blood the rate of clotting would be increased for a limited period until normal calcium equilibrium was again established. The determinations of clotting time made on May 28th do not support this idea, although it is possible that there was evanescent shortening of clotting time after the injection, which had disappeared in 4 hours 20 minutes. On the other hand, clinically the effect of the injections took thirty-six hours to develop, and on the occasion of the last injection there was a distinct diminution of the clotting time in four days. An explanation of this phenomenon is to seek, but it would be of interest to see whether other hæmophiliacs show the same effect. The results in this case have no bearing on the possible utility of intravenous calcium in arresting hæmorrhage in people whose blood clots normally.

Calcium given by the mouth had no apparent effect in the first instance, but, when given after the last injection, it appeared to be useful in delaying the return of slow clotting.

The solution employed for intravenous injection contained 0·66 gramme (10 grains) calcium lactate in crystals and 0·7 gramme sodium chloride in 100 mils distilled water. This was washed into the vein with 0·9 per cent. salt solution in distilled water. No rise of temperature followed the injection except on one occasion when faulty distilled water was employed in making the saline.

In conclusion, we desire to thank Mr. Dunn for permission to publish this case.

P. R. BOSWELL.
J. H. RYFFEL.

A Night in the Belgian Trenches.

BY A GUY'S MAN.

LAST Saturday some soldiers billetted at a farm up the road came to give us a revue written by one of their number. We put up a stage for them in one of the big wards and crowded in as many patients as possible, also a lot of visitors. The actors also brought about 15 members of the Belgian military band with them for an orchestra. It was really great and comical—all in French Flemish. Some of the parts in it as far as one could understand would have been quite "de trop en Angleterre!" We were just taking the officers, etc., down to tea when Her Majesty turned up laden with chocolates, flowers, and smokes for every one of the patients. She was here for about two hours, and as she was departing the military band played the National Anthem, and the rest cheered. It was just the right ending to the day, and was quite thrilling.

On Sunday night two of the Sisters, Dr. Shaw, and myself went to dine with the officers (of the soldiers who acted for us). They belonged to a company of mitrailleuses—a commandant, first lieutenant, and one sub. (the other sub. was away in the trenches). Fortunately for me one of them could speak English. They had decorated a little room in the farm for us, and one of the soldiers cooked. It was most frightfully jolly, and they were as pleased as we were. It was about a seven course meal, with wine, fizz, liqueurs, and coffee! We were thoroughly enjoying ourselves when, at the liqueur stage, a message came to the commandant to say that his company was wanted at a certain place to back up the other company as they were expecting an attack. So, as I had been promised a night out with them, I asked if I could go straight away, and he readily consented. So I dashed back here and put on my long boots and returned to the farm to finish off my liqueur and wish the rest of the party au revoir.

The Commandant and I rode our bikes (without lights) till we caught up the company, and then we marched with them for about six kilometres, I suppose; anyway, it began to thrill me from the beginning. Up to a certain point we could smoke, after that—no lights and subdued talking—our road running between the floods, with evidence of shell fire on either hand—silently through a bombarded village with its gaunt ruins visible against the starlit sky. These appeared still more weird when lighted up by the glare of the magnesium rockets which the Germans send up every few minutes to guard against surprise attacks. After the village came another long stretch of road again with floods on either hand. Each time a rocket went up we all ducked as low as possible so as not to make a target against the sky; also we had instructions to throw ourselves flat on the ground or run behind the nearest tree if we heard a shell coming our way; luckily none came.

Soon we came to another village, which we skirted for safety's sake, and at last reached the trenches, where I rested in a dug-out and had a cigarette for a few minutes. Then the commandant took me on to another place, telling me to follow him at ten metres and to do whatever he did. This was the most thrilling portion of the whole road. I crouched as low as I possibly could whenever a glare went up, because the Germans were only just to our right and could pick us off with rifles. We clambered over fallen trees, and "sloshed" in mud, but reached our cave in safety, hot and weary. The commandant was most awfully decent to me all the way, and frightfully keen to know if I was interested in it all, I thanked him as cordially as my French would permit. He left me in charge of the officer and went off, bidding me a cheery "good night."

Our little cave was bomb-proof and very small. After half an hour I crawled out. I suppose it was about 2.30—3 a.m. It was honestly an extraordinary feeling, seeing the men crouching low behind their barracades and firing at (what were to me) unknown and invisible targets. Of course, I did not know the lie of the land, and coming along that last bit of road I did not take much note of its course. I crouched, too, till the officer (whom I knew before) told me I had better come along with him; so in inky darkness I crawled through a small hole in a ruined cottage, and I was not able to make out where I was till daylight broke some hours later. I lay fairly comfortably on straw with my back against a wall. There were about three of us present, as far as I could make out in this hole, and at intervals the officer would dash out to give some orders. He told me that at 4 a.m. they on the right were going to make an attack on the Germans, while we in our position were going to keep them busy on the left with mitrailleuse. Well, I was frightfully excited, and then it began.

The rat-tat-tat of the maxims, the rifles, and shells! The air seemed to be alive with the whistlings and explosions of them, and we in our hole often wondered whether those that burst a few yards off were meant for us or the German trenches, and, too, sometimes morsels of brick and dust hit us in the face as the results of bullets striking the walls near by. I really did tremble a bit, because I did not know the difference in sound between a German or a Belgian shell, especially, too, as we were less than a stone's throw from the German trenches. However, by about 6 a.m. things began to quiet down, and I

heard that the object had been achieved, and I was glad to have been present. Now as daylight was becoming stronger I found I was in a small low room about 10 feet by 8 feet and 4 feet high. I was beginning to feel cold and hungry. At 8 we breakfasted (a haversack having been provided for me). After that the officer took me out on my hands and knees, and I was able to see what a precarious position ours was. I saw the Germans (two) in their trenches just across a little stretch of water, and could have easily shouted to them. I did not look long in case they might have spied my head! I took four photos; after events showed that they did not come out well, except one which is really the most interesting. For the rest of the day (it rained till night) I lay in our little room (which sometimes contained ten of us), and talked, ate, and slept, with an occasional crawl on my hands and knees! When I was not eating or sleeping I felt myself devoured by fleas; it was awful, and I could not stand up and scratch myself comfortably. The officer made it an opportunity to learn English, and I willingly helped him.

That night the company had finished their turn in the trenches, and we were looking forward to a well-earned sleep in the farm back here. However, they could not start back before 10.30, so the lieutenant gave me a corporal as guide and companion (he knew him in Brussels "avant la guerre"), but he could not talk any English, and I French "un petit peu." Our journey began with the dangerous bit, and I was rather worried because we got in with a bunch of a dozen soldiers returning, and it made me think what a good target we should make, and I longed to order them to march in single file. At the end of the road we reached the village which we had skirted before. A house was burning in it, and a shell flew over our heads and dropped in the floods not far off. To my horror my guide was taking me through the village, and I had to tell him that it was safer to go round, but he said, "No, it is quite safe," so there was nothing to do but go with him. I tried to hurry my steps. The burning house was fascinating, but I noticed that the few soldiers present did not linger, and kept close to the houses; my guide (who, by the way, won the Croix Militaire at Dixmude some weeks ago), however, marched boldly down the centre. He told me as we went that a spy had been shot that night by the Belgians for cutting the telephone wires. The way seemed much longer on the return journey, and I began to long for the part where we might again light a match for a smoke—a cigarette; after that I longed for a drink—beer! I was walking in rubber knee boots, and they were beginning to fag me. However, I knew that as soon as I reached the hospital I would be regaled with supper (*i.e.*, the night nurses' breakfast), so we continued at about four miles per hour. At last we reached his village, and then I had two glasses of sour wine, but I did enjoy it. The last kilometre I finished with my pipe, just reaching the farm as the company were at the gates. They all greeted me, and I felt so pleased, thankful that I had seen what I did see safely, and that the lights of home were visible. By George, I was delighted not to have to spend another night in the flea-inhabited hole. I suppose the soldiers are used to them!

I had just got to sleep when, at about 4 o'clock, I was called to attend a blessé from the very place where I had been and whose photo I had taken that morning. Since then we have had about six men in, one of them being one of the chief actors in the revue mentioned above. About mid-day a pal [?R.S.O., Ed.] and I went to the farm to pay our respects to the commandant. Awaiting his arrival we were regaled with drinks and invited to lunch, for which the commandant arrived in time. It was a very enjoyable lunch, too, and we had our photographs taken. They promised to come to dinner with us as soon as possible.

That happened to be the last time any of us here at the hospital were to see the commandant. Poor man! It was two nights later that we had fixed up for the dinner, when we heard from one of the blessés that the Belgians had been driven out of their advanced position (the scene of this account) by a German bombardment which commenced the day before and continued all night. They say it was terrific: 2,500 shells on that place, 200 in half an hour. What caused us all more grief than anything was the fact that the commandant had been wounded (in five places) and had refused to be carried away. We heard a fortnight later that he had died of his wounds as a prisoner in Roulers. I have seen the officer with whom I spent the night, and he says that not one of the younger officers whom we knew were on duty, happily, at that post during the cannonade.

Well, it is all very strange. I cannot say that we are never callous, but of this I am sure, that not one of us realises what the war means until one or more of our relations or friends, either life-long or acquaintances, are wounded or killed, and it is so in this instance of the commandant, who made himself our friend for so short a space of time, but whom none of us who knew him will ever forget. In a phrase so simple, but so true, that only those who have been "out there" can understand, "Mon Camarade!"

Papers by Guy's Men.

Sir Geo. H. Savage, M.D., F.R.C.P.: Hospital treatment and lunacy treatment.—*Lancet*, July 31st, 1915.

Medical Midshipmen.

A CERTAIN major was asked by a zealous subaltern what was the best way to gain a medal for a campaign. "Sleep in stagnant stables for six months, and see six minutes' fighting," said the major. Anyone who will do that cheerfully certainly deserves all the kudos he can acquire, and a little more; but it is not the language used by that fraudulent race of recruiting sergeants. Neither do the Admiralty advertisements for surgeon probationers give a hint of coal dust, oil and influenza. Yet, indeed, to volunteer as surgeon probationer is by no means to enjoy the pleasant yachting cruise that some people imagine. Destroyers are not roomy craft, and any superfluous addition to the crew —remains superfluous. In the new boats one has a small cabin. In the older boats there is a choice between the ward room sofa and a hammock slung under the hatchway. The hammock is to be preferred, as one need not turn out so early. But in either case you will have to wait the pleasure of some one else before getting a bath. If your captain is good-tempered you may be sure of getting on well with him. If he is crusty with excess of port you will be reminded that you are a mere probationer at least twice a day.

These will seem minor details to the enthusiast. Well, his enthusiasm will have to endure the greater shock of an entirely necessitous idleness. If anyone with a talent for laziness will spend a few months as doctor in a destroyer, the result will be a complete cure. But I am preaching unorthodox homœopathy. Still, in a little over six months, the present writer had these few serious cases, all of whom had to be sent ashore at once, there being no means of treating them on board, bar a medicine chest full of purgatives.

Item: One fractured tibia, one lacerated hand, both due to the engine-room.

Item: One nephritis, due to whisky.

Item: One bronchitis, due to the North Sea.

Item: Three cases of ——— and one case of ——— all due to ———.

Item: One case of acute gastritis, due to the Lord knows what.

Item: One case of ptomaine poisoning, due to tinned fruit.

Besides this, the engine-room artificers occasionally attempted to cut their nails in the reversing gear, with the result that the writer fomented some half-dozen septic finger-ends. Also, he was woken up at midnight in dock once, to certify a man as drunk. That is all, except a few neurotic stokers and a few chronically constipated A.B.'s.

As a counterpoise to this sumptuous experience, his ship put to sea three times at 2 o'clock of a winter's morning, under the impression that she was going into action, and he saw, and nearly felt, a most accurately-shooting Zeppelin. As a further counterpoise, he will be told that he had an excellent opportunity for arrears of reading. But reading without practice is mustard without beef. Also, in harbour, a gramophone was played for two-thirds of the day! for the remaining third he mixed, and drank, cocktails with the sub. At sea he ate and slept and ate again, and gave first-aid lectures. On leave—but there! Why stir the ashes?

That is a fair summary. If anyone will be content to forget a half of what he once knew tolerably well; if anyone will be content to see as many cases in two months as may be seen in one hour at the front surgery; if anyone will be content to dose a bilious crew with calomel, pil. col. et Hyos., castor oil, Dover's powder, quinine or boracic acid tablets, then the Lord be with him, for his faith shall make him a surgeon probationer.

On the other hand, there is a certain feeling of responsibility to be gained, and there is always the chance of going into action and finding rather more work than one has thought likely. One man had sixteen more or less seriously wounded under his charge for thirty-six hours. But the North Sea is almost the safest part of England at present.

Were the Admiralty to make it a three months' appointment, instead of six, it would be an excellent experience, and an introduction to the Navy for such as wish to enter it later as full surgeons. Six months, however, leaves one like patience on a monument—or full of strange oaths.

Appointments.

Civil.

Honorary Visiting Surgeon, Government Civil Hospital, Hong Kong (dated June, 1914):—Ho-Tung, Professor of Clinical and Operative Surgery, University of Hong Kong (dated February, 1915).

Naval.

To be temporary Surgeon:—E. Granger.

Royal Army Medical Corps.

The undermentioned Captains to be Majors;—R. G. Anderson, T. C. Lucas, S. C. Bowle, H. C. Winckworth.

The following Lieutenants to be Captains (S.R.):—R. B. Campion, M. K. Nelson, H. C. Rook, F. D. Annesley, J. L. Perceval, S. Wickenden, G. Marshall, C. de W. Gibb, T. B. Heaton, J. A. Ryle, G. T. Mullally, R. C. Ozanne, D. C. Scott, A. L. Anthony, W. M. Lansdale, H. P. Whitworth, F. V. Bevan-Brown, E. C. W. Starling.

2nd Northern General Hospital:—Major W. H. M. Telling to be temporary Lieutenant-Colonel.

3rd Western General Hospital:—Capt. E. Reid to be Major.

Attached to other than Medical Units.

Lieut. J. H. Robinson, from 2nd Welsh Field Ambulance, to be Lieutenant.

Nerves and the War.

CLINICAL LECTURE BY ARTHUR F. HERTZ.

II.

Gentlemen,—In a Clinical Lecture published in the Gazette of April 10th, I gave an account of some of my observations on nervous disorders among soldiers invalided from the front. To-day I shall discuss certain questions in diagnosis and treatment, the importance of which has become more apparent with increasing experience.

The diagnosis and treatment of nerve injuries.—Loss of function in the distribution of a peripheral nerve may be due to actual division by a bullet or less frequently by broken bone, to compression by effused blood and subsequently by scar tissue, and to concussion, which I mentioned in my clinical lecture as a condition unknown before the present war. Actual division requiries operation as soon as the wound has become absolutely clean; in most cases of compression by scar tissue operation is required, but paralysis following compression by effusion of blood will eventually disappear, and recovery invariably occurs without operation sooner or later after concussion. The diagnosis between these conditions is therefore of the utmost importance. As a divided nerve does not often regain all its functions until over a year has elapsed since its restoration by operation, it is clear that delay is most undesirable.

In a few cases the history of what happened at the moment the injury occurred gives the clue to the diagnosis. When, for example, a bullet has divided the musculo-spiral nerve, the hand and fingers may suddenly pass in a condition of extreme extension which is followed a few seconds later by complete paralysis with dropped wrist and flexed fingers. The excitement and pain and the occurrence of other injuries at the same moment generally prevent these phenomena being observed, if, indeed, they always follow division of a nerve, but when there is a clear history of their occurrence there can be no further doubt that the nerve was actually divided.

The slightest voluntary movement in any of the muscles supplied by the affected nerve shows that complete division cannot have occurred. The absence of cutaneous anæsthesia, the presence of an area which is much smaller than that supplied by the nerve, or the shady retraction of the area points in the same direction. Experience has shown that the cutaneous distribution of peripheral nerves is much less constant than was formerly supposed, so that too much importance should not be attached to slight variations from the text-book descriptions of cutaneous nerve distributions. This also applies to the muscular distribution of the roots of the brachial plexus; it is often, indeed, extremely difficult to localise the exact part of the plexus which is involved. The enormous experience which will be gained during the war of the results of nerve injuries will, in my opinion, act as a death-blow to the theory of epicritic and protopathic sensibility, which I have always thought was founded on insufficient evidence.

The sensory nerve fibres of muscles run in the same peripheral nerves as the motor fibres, so any injury to the latter resulting in paralysis should be accompanied by loss of muscle sense in the affected muscles. In numerous cases in which paralysis has been complete I have found that pressure upon the paralysed muscles. or wherever possible as with the calf-biceps and biceps, nipping the muscle between one's fingers has given rise to the same sensation on the affected side as on the normal side, and in some cases the muscles have actually been hypersensitive. In most cases I have advised against operation, as I believe that the paralysis cannot have been due to division of the nerves.

In my opinion the only electrical test which is of great value in these cases is the response to faradism, this being perhaps the most important diagnostic sign of all. The muscles should be tested with a faradic current, the strength of which is progressively increased until either a response is obtained or the patient cannot bear a stronger current. Many patients have such an irritable nervous system, as a result of all they have passsed through, that they can only bear comparatively weak currents, and it is very unusual to find a patient who can bear really strong ones. If no reaction has been obtained and the other evidence is inconclusive, the patient should be given an anæsthetic, when the muscles can be tested by currents far stronger than would otherwise be possible. I have had several cases in which a response to faradism was obtained in this way, and in which the subsequent course of events showed that the postponement of operation was justified. When no response is obtained under the anæsthetic and there is no other evidence indicating that the nerve is intact, an operation, which can

be performed under the same anæsthetic, is definitely indicated. So far in every case the nerve was found to be divided or so involved in scar tissue that recovery without operation would have been impossible. It is likely, however, that this will not be found to be an invariable rule. But no harm is done by an exploratory operation under most conditions, and the possibility of an occasional unnecessary operation is more than outweighed by the harm which would be done by delay in the much more numerous cases in which operation would eventually be required. In my opinion a battery and sterilisable electrodes ought to be available at every operation on nerves. If, for example, a nerve is found to be embedded in scar tissue, the question often arises whether the part involved should be excised and the divided ends then united, or whether it would be sufficient to free the nerve as completely as possible from the surrounding tissue. The nerve above the injury should be directly stimulated by a very strong faradic current: if there is any response in the muscle it supplies, the latter course should be adopted, as the former would result in an added delay of many months before complete recovery could occur.

In a few cases of injury to the brachial, and in one, to the lumbo-sacral plexus, I have seen more or less rapid recovery occur in part of the distribution of a nerve root, the other muscles remaining completely paralysed and giving no response to strong faradism. The explanation must be that the nerve has been partially severed. In such cases, unless the nerve root is easily reached, which is very rarely the case, I believe it is wise to wait for several months or even a year to see whether recovery does not take place without operation, as it is doubtful whether the position of the divided fibres could be greatly improved by surgery.

There is one further indication for operation, which may be present even when paralysis is absent or incomplete and there is no anæsthesia. This is the presence of severe pain in the distribution of the affected nerve. In one case seen with Dr. Fawcett this was associated with remarkable vasomotor phenomena, the foot becoming bright red and extremely painful the moment it was allowed to hang. Pain was also present, though less severe, when the leg was raised and the flushing absent. Sir Alfred Fripp freed the nerve involved in scar tissue, and slow but steady improvement followed the operation. In all such cases the nerve has been freed in a similar condition, but the immediate result of operation is not always so satisfactory: in another case of Sir Alfred Fripp's, for example, improvement only began to be noticed after several weeks had elapsed.

It is sometimes difficult to understand how the paralysis observed could be produced by the injury. The possibility of some accidental cause should then be considered. I have, for example, seen severe paralysis of all the muscles of the arm result from the application of a tourniquet, no nerve having been injured by the bullet at all. In other cases, badly-applied splints have produced paralysis, and in one case musculo-spiral paralysis of the familiar "Saturday night" variety occurred owing to the patient having lain for several hours with the nerve compressed, as he was unable to move his arm in spite of its uncomfortable position owing to a nerve wound of the shoulder joint.

The treatment of aphasia.—There is very little scope for the treatment of aphasia in ordinary civil practice, as in a large majority of cases it is the result of some progressive disease such as a cerebral tumour, or it occurs in elderly patients in whom re-education is difficult or impossible. When, however, it results from a wound the conditions are ideal for treatment, as the loss of function is partly due to concussion, the effects of which gradually pass away, and partly to pressure, which can often be relieved by operation, and the patient is generally of the age most suitable for re-education, as his brain has not yet begun to lose the receptiveness of childhood whilst the importance of diligent application is better understood than it could be in a child. In some cases aphasia and the associated hemiplegia rapidly improve before any treatment beyond what is required surgically has been given. In an officer I saw with Dr. Douglas Shields six weeks after the wound had been received there was only occasional difficulty with certain words, although for fourteen days the aphasia had been complete, and beyond slight weakness in the lower part of the right side of the face no symptom or sign of this patient's hemiplegia which was originally present could be found. In such cases the speech centre cannot have been actually damaged, the aphasia being due to the concussion produced by the impact of the bullet in its neighbourhood, and to a less extent to the pressure caused by the effusion of blood and serum, which have since been absorbed or permitted to escape as a result of operation. In other cases improvement is very

slow, and unless systematic treatment is adopted and patiently followed for a long time, speech will remain permanently very imperfect. I believe that the effect of treatment is to develop the hitherto undeveloped speech centre on the right side of the brain. Doubts have been raised in the past as to whether such an event is possible, but some of the cases I have seen can be explained in no other way. Sir Alfred Fripp asked me to see an officer with a septic bullet wound in the left side of his head. He had been wounded about a week before and had been trephined whilst still in France. He had complete right-sided hemiplegia, and "yes" was the only word he could say. In addition to the aphasia he was in the dull mental condition characteristic of cerebral abscess, and his temperature was irregular, rising at times to 104°. I was sure that an abscess was present, but I felt some doubt as to whether it was justifiable to advise operation, as death would be preferable to the living death of a highly-intelligent man completely aphasic and almost completely hemiplegic. Thinking, however, that the latent speech centre on the right side of the brain might develop, and as I did not think that the left centre was likely to be so seriously damaged that walling would not be continually possible, I advised operation. Sir Alfred Fripp found a subcortical abscess, which he opened. The temperature at once fell to normal, and the subsequent surgical course has been entirely satisfactory. The next day treatment by re-education was begun. At the end of five days the patient could say "No" as well as "Yes." New words were then added every day, and the patient can now—three months after the operation—carry on a conversation with only occasional difficulties, and can write very well with his left hand. I hope on some future occasion to publish the patient's own account of his recollections, which date back to the time before the second operation; as he is a man of unusual intelligence, the account of the mental processes which accompanied his returning power of speech should prove to be a very interesting psychological study.

Lessons should be given regularly twice a day. They should not last more than five minutes at first, as fatigue occurs very rapidly, but their duration can gradually be prolonged. New words should be taught by the continuation of auditory, visual and visual-word impulses: thus the word dog should be repeated and at the same time a picture of a dog and the letters D O G should be shown to the patient, or his hand should be touched at the same time as the word hand is pronounced and the letters H A N D shown. As soon as a new word is mastered, words derived from it should be added, such as "yesterday" after "yes," "note" and "nobody" after "no." A record of the vocabulary should be kept, and each lesson should begin with a rehearsal of the most recently acquired words. After a short time new words will be spontaneously acquired, and these also should be added to the list. From the earliest stage the patient should be taught to write with his left hand. The aphasia is almost always associated with agraphia, but the two are not absolutely parallel, so that education in speech and writing are mutually helpful. Words should at first be written in capitals and copied several times; later they can be written in ordinary characters.

The patient already referred to, has now acquired his former handwriting with his left hand, so that it is difficult to distinguish recent specimens of his signature from specimens dating from the time before he was wounded. An additional reason for teaching the patient to write with his left hand and to use it as much as possible from the earliest possible moment, is that the acquisition of left-handedness probably helps the development of the new speech centre. People who are left-handed from birth have their speech centre in the right side of their brain instead of the left, as they develop aphasia with left hemiplegia and not with right hemiplegia; it seems likely therefore that people who become left-handed later in life will simultaneously develop a corresponding speech centre if the old one on the left side is no longer available.

The treatment of the aphasia of soldiers is a most interesting and gratifying task. If none of the patient's relations are available, or if they have not the necessary ability, it affords one of the most useful employments to the many willing voluntary workers who have no previous experience in nursing, but wish none the less to give what help they can to the wounded.

Diagnosis and treatment of organic and hysterical hemiplegia.—The organic nature of cases of hemiplegia due to wounds of the motor area of the brain, such as those mentioned in connection with aphasia, is generally obvious. Complete or partial hemiplegia, monoplegia and crossed paralyses frequently result from the concussion produced by the explosion of a "Jack Johnson" in the near neighbourhood of the patient. He is rendered unconscious, and finds that he is paralysed when after a varying interval he

regains consciousness. A diagnosis must be made in such cases between hysterical paralysis and paralysis due to some gross central lesion produced by the concussion. In some cases there is an organic basis with a large hysterical element added. It is remarkable how commonly hysteria occurs under such circumstances, even among patients who are not in the least neurotic. This emphasises how erroneous was the old idea of hysteria as an equivalent of the "vapours," a condition supposed to be almost confined to foolish and emotional women who were more or less completely devoid of self-control. One is constantly met with the objection that a man who is suffering from hysterical paralysis is not "neurotic," and cannot therefore be hysterical, and particularly among the laity, the idea of hysteria carries with it a notion of something derogatory,—something of which a man should be ashamed. This is, of course, absurd; hysterical symptoms are merely symptoms which have resulted from auto-suggestion, and which are curable by persuasion and suggestion.

There are numerous physical signs of organic hemiplegia. In organic hemiplegia involving the face, the platysma of the affected side is paralysed; in hysteria it is unaffected. In organic hemiplegia, if the supinated arm is completely relaxed and when trussed it falls in a position of pronation, but in hysteria it does not turn. When a patient with organic hemiplegia grips the observer's hand with his normal hand, an associated movement occurs in the paralysed hand unless the paralysis is too complete, but no such movement occurs in hysteria. The tendon reflexes of the arm and leg are almost always exaggerated on the affected side in organic hemiplegia and then ankle-clonus is often obtained, though they may be absent or deficient in the early stages; in hysteria they are invariably equal on the two sides, and then ankle-clonus is never present. The abdominal reflex on the paralysed side is weak or absent in organic, but equal to the opposite side in hysterical paralysis. The plantor reflex is generally, but by no means always, extensor in the former, invariably flexor in the latter (Babinski's sign). When a patient tries to raise himself from the horizontal to the sitting position with his arms folded and his legs widely separated, the paralysed leg rises higher than the other in organic disease, but remains on the ground in hysterical hemiplegia (Babinski's second sign). In a well marked case of organic hemiplegia, most or all of these signs are present: in hysteria, no single one is present. In many cases of hysteria the diagnosis is made still more certain by the gait or some other prominent feature being of a nature quite unlike anything seen in organic disease. In other cases, some inconsistency about the symptoms points to hysteria. An officer became hemiplegic on the right side after being blown up by a high explosive shell in the Dardanelles. He was taken to Cairo and then sent home. When he said good-bye to his father, who came to see him at Cairo, he shook him strongly by the hand. He told me of this as a remarkable incident when I saw him in London. He was cured at once by suggestion during hypnotic sleep.

The following is a good example of the difficulty in diagnosis when hysterical and organic symptoms are present in the same patient.

Paresis and involuntary movements following concussion caused by a high explosive shell.—Private M., aged 29, was knocked over by the explosion of a high explosive shell in December, 1914, and remained unconscious for two days. When he regained consciousness, he found that he could not move his right arm or his left leg. Power in both limbs soon returned to some extent, but as soon as he tried to stand, violent involuntary movements occurred in his left leg.

I first saw the patient on April 1st, 1915. His mental condition seemed to be impaired, he only answered questions after a considerable latent period, and his speech was slow. The whole of his right arm was weak, the grip being particularly feeble. When he clenched his left hand an associated movement occurred in the right hand, but on clenching the right hand no similar movement occurred in the left hand. The muscles of both arms were equally well developed. The tendon reflexes in both arms were brisk, but were no better marked on one side than the other. The patient was unable to localise light tactile stimuli accurately, but otherwise there were no sensory disturbances. All movements of the left leg were somewhat weak. The muscles were equally well developed in both legs. Both knee-jerks were brisk, the left one being slightly brisker than the right. Well-marked ankle clonus could be obtained on the left side. The plantar reflex was constantly flexor on both sides, but Babinski's second sign (combined flexion of the thigh and pelvis) was very well marked on the affected side. As soon as the patient attempted to walk, violent involuntary movements were set up in the left leg: the leg moved rapidly rom side to side round the point where he toes were in contact with the ground.

When a step forward was taken with the right leg, the left leg dragged behind and very irregular movements occurred. The gait seemed to be of so obviously hysterical a nature and the signs pointing to organic disease were so slight, that it was thought that all the symptoms would probably be cured by suggestion. The patient was kept in hospital for a month, but all efforts to cure him by means of suggestion entirely failed. He proved very easily hypnotisable, but even when deeply hypnotised the movements of the leg could not be controlled when he was told to walk. Dr. Batten suggested that etherisation might be of use, but the first wiff of ether had the effect of hypnotising him. He is now, at the end of July, in exactly the same condition as when he was first seen, except that his mental condition has improved.

The associated movement of the paralysed hand when the normal hand contracts, the slight exaggeration of the left knee-jerk and the tendency to ankle-clonus, and above all the presence of Babinski's second sign, indicate that some organic changes have occurred in the brain as a result of the concussion. The complete failure of suggestion to produce any improvement raises the question whether all the symptoms, in spite of their unusual character, may not be organic in origin.

The possibility of malingering has been raised in this case, but from what I have seen of the patient I do not think it is at all likely. Moreover, the evidence against a purely hysterical origin is equally strong against pure malingering, as the symptoms of hysteria and malingering are identical, the paralysis and other symptoms corresponding to the patient's own ideas of paralysis, which are sub-consciously produced in hysteria, but consciously in malingering. The signs of organic paralysis are simply those signs which are not associated with the idea of paralysis in the ordinary lay mind. Hysterical paralysis or malingering in a neurologist could only be diagnosed by a neurologist who knew signs of which the patient was ignorant.

A good deal can be done in the way of treatment for organic hemiplegia. The paralysed limb should be massaged from the beginning, but when spasticity develops, the massage should be done more and more gently, and passive movements should be regularly carried out to prevent contractions. The tendency to contractures can also be overcome by the use of splints kept on during the night, and in severe cases during more or less of the day. An officer with hemiplegia and aphasia due to a wound received three months before, could only use his right hand very little on account of the contraction which kept it tightly flexed; he improved greatly as a result of having the fingers fixed in a position of hyper-extension by a splint during the night.

When an arm is completely paralysed the patient should clench his normal hand as strongly as he can several times a day in order to encourage the development of associated movements. As soon as these appear in the paralysed hand voluntary movements will soon begin. Electricity should be avoided unless the paralysis is extreme and the limb is flaccid instead of spastic. The contractions produced by faradism may then encourage the patient to begin voluntary movements sooner than could otherwise be the case, as auto-suggestion often results in prolongation of paralysis due to upper neuron as well as to lower neuron lesions, after the return of voluntary power has become possible.

Hysterical paralysis occurring in soldiers has proved very amenable to treatment. Though treatment by persuasion is perhaps preferable to hypnotic suggestion, the latter produces more rapid results, two or three treatments being generally sufficient to complete the cure. I am convinced that everybody who has to deal with soldiers suffering from neuroses of any kind ought to learn to hypnotise them himself. There is no difficulty about it, as shown by the fact that every one of my clerks in the neurological department, who has tried, has succeeded after the first or second attempt, and the process so far from being fatiguing is much less laborious than the alternative methods of treatment. I hope on a subsequent occasion to describe some of the results we have obtained by hypnotism in the treatment of insomnia, nightmares, hysterical paralysis, tics, and stammering, resulting from exhaustion, shock and other causes in soldiers.

For the benefit of those men who intend taking Surgery in the next Conjoint Examination, a course of Operative Surgery has been arranged to take place in the Dissecting Room during the first fortnight in September.

Our Nurses in France.

MANY articles have already been written in praise of the various units in the British Army, including the Royal Army Medical Corps. More will undoubtedly appear. In this it will be my object to write a short eulogy of our nurses. So far, it has been my good fortune to work as a Medical Officer in almost every department from the base to the actual firing line in France. Later it was my equal good fortune to occupy the position of a patient in a military hospital. I offer this varied experience as a justification for this article.

In the early days of the war conditions were bad. Orders were being issued, cancelled, and changed with extraordinary rapidity. One day we would open out a hospital, next day we often moved away, having then to evacuate all our patients. On the third day, we might find ourselves attached to an entirely different unit. As a result of the retreat from Mons the entire base was moved away suddenly. During this time some of our nurses had very rough experiences, and little attention. They always worked with untiring energy, and helped to cheer us all with their enthusiasm. However, it is in the actual ward work that their help and experience has proved invaluable. Nursing at an ordinary civil hospital under normal conditions is seldom light, generally heavy. Under war conditions, with a stream of serious cases continually passing through, the work can only be realised with actual experience.

I would remind you that every patient has to be washed, clothed, dressed, fed, and made as comfortable as possible. The less serious cases are passed along quickly, the worst cases are kept until more fit to travel. Added to this worry is the scarcity of male nursing orderlies. A good orderly is worth his weight in gold to any ward sister. All are keen and willing to learn, but the education of these men has greatly added to the work. At first the responsibility was even greater than it is now. Often, medical officers were unable to give anything like sufficient attention to each individual case. Nurses did most of the dressings, while we got along with other ward or theatre work.

In some wards every case was serious, and it was often impossible to guarantee that any single case would not hæmorrhage. With the arrival of bad cases of gas poisoning our work increased many times over. Oxygen given at frequent intervals seemed to be the only efficient method of relieving the poor sufferers. You can imagine the night sister rushing around a crowded ward trying to distribute her attention correctly.

The atmosphere in our wards was generally thick. At times the stench was overwhelming. Of worries there are many, and not the least is the mania of some authorities for tidiness. You can imagine the difficulty of keeping wards really clean when cases often arrive, depart, and are dressed simultaneously.

Ward correspondence occupies a large portion of a sister's leisure moments. Endless enquiries arrive from the relatives of the dead, or from the anxious friends of the wounded.

I could continue thus, but think it will suffice if I say that the work often seems endless. Pay is not too generous, and a large portion has gone to satisfy the extortionate demands of some billet-keepers. Of recreations there are practically none.

At first the question of seniority caused trouble, and it is not surprising when these nurses came from every hospital in the United Kingdom. Still everything is working smoothly now. Almost every nurse is good; some are magnificent. We medical officers always value their help; often we are only too grateful for their advice.

In conclusion, their work is invaluable, though often it may not be obvious. It is to be hoped that those nurses who have given up good posts at home to go out on foreign service will have their posts returned to them later. I would suggest that they might even be given preference when applying for fresh work after the war.

L. G. D.

A Visit to South Kensington.

IT was Wednesday morning and I walked into the breakfast-room quite early. The Forward was there, placidly engulfing his second helping of porridge, generously crowned with crisp brown sugar from Demarara.

"Hullo," he said, "you look worried!"

"I don't," I retorted crossly.

"You looked worried," he replied aggresively. (The Forward is large and long—have you seen a baby "hippo?")

"Perhaps I am rather whacked," I confessed. "You see I have been working for a week and the Pharmacology paper comes off at 10."

The Forward checked a most delectable mouthful of haggis in mid-air and, with the terminal phalanx of the left index finger, meditatively traced the surface marking of the temporal artery of that side.

"By Jove! so it does," he said (an angelic smile displacing his usually placid facies). "What's the dose of Atropine?"

"Ten per cent." I told him.

"Isn't it 2—4 fluid drachms?" asked an enquiring voice.

We looked up to see the Scribe, genial and debonair, his face still glowing from the morning tub. He sat down and then carefully opened the familiar red book.

"I have been working very hard," he announced presently. "Began yesterday afternoon—hot work—at least it would have been if I hadn't fallen asleep. Do you chaps know the tip for Ergot? Ergot expels . . ."

"Shut up,' said the Forward.

"Ergot" insisted the Scribe firmly, "makes the 'Active Indian Hop.' I spent all yesterday afternoon learning that, so I know."

"By the way, what's the dose of Caffeine?" asked the Forward.

"5—15 grains (unanimous).

"I'm going to take some to buck me up." he stated.

He took 20!!

By this time it was 9.15 and we realised that the Midwife had not yet put in an appearance, so the Forward dashed upstairs to rouse the indolent "gamp." On re-entering, the ravages of the Caffeine were all too evident, and he startled the peaceful handmaiden by ordering the Midwife's breakfast thus—

℞ Porridge 4—8 ozs.
Extractum Liquidum Caffeini (hot) 16 ozs.
Ova Cocta mitte 2
Laminæ panis tosti mitte 3
stat.

It was 9.30 before we all met at Grays Lodge.

"I think a Taxi is indicated if we are to get there by ten o'clock," I suggested timidly.

The Forward regarded me scornfully. (As you know he is a very capable forward and he had ever so many grains of Caffeine inside him).

"Taxi!" roared the Scribe, "I've got Atropine, Morphine, and Chloral to read up, and a Taxi goes much too fast. We'll go by 'bus."

By 'bus we went.

We arrived at 10.25, and headed by the now irrepressible Forward, we wandered into the Examination Hall, where we sought our seats to the accompaniment of the thunderous stamping of feet by the multitude already assembled there.

* * * * * *

A week later, we once more leisurely made our way to that same fell spot. With pallid faces and hair dishevelled, we faced each other and hardly a word was spoken. For on that day each man's voice had to repair the damage his pen had wrought.

The Scribe was the first to be called, and only a silent hand-clasp sped him on his way. Then followed the Forward, then myself, and there only remained the Midwife, but he, with characteristic foresight had tipped the Porter to wish him "God-speed."

When the ordeal was over, and we had summed up the Examiners as only Medicos can, we hastened back to the station, and guided as if by some strange fate, we sought the refreshment room. Four tankards of ale were quickly dispensed and we drank to our success—improbable but possible.

* * * * * *

Now a fortnight has passed and this morning, the Forward dashed up to me wildly flourishing a Pass-list and mirabile dictu! it contained the names of the Forward, the Midwife, the Scribe and myself. I suddenly felt faint, but managed to gasp out "strychnine!" As I lost consciousness, I distinctly remember the stab of the needle in my bared arm, and a distant voice muttering "strychnine, strychnine? ¼—1 grain. Dare quam accipere."

M. M. cum M. S.

Correspondence.

To the Editor of Guy's Hospital Gazette.

Dear Sir,—There is a road somewhere in Gallipoli that slopes down into a valley between two little sandstone hills. Beyond rises Achi Baba and the mythical village of Krythia.

I want you to visit a dressing station which is situated in a ruined Turkish cottage. Captain Cogan (Guy's 93–98) is sitting by the wall contemplating over the *Northampton Independant*; he looks up as a shell pitches about 100 yards away, throwing up a cloud of dust, but resumes his paper. At that moment a figure resplendent in naval khaki and wheeling a captured bicycle, walks up and demands to be told where — Brigade are. Unfortunately he has asked Symns who is more interested in cleaning an ancient pipe.

However, Schlesinger and he recognise one another, and enter into an animated discussion on "short circuiting." They retire to tea and are joined by Creasy disguised as a naval officer with a magnificent black beard. Elliot and Rankin are out here, looking delightfully cool in white ducks on the hospital ship *Somali*. It is very fashionable to row out to them in the evening for an iced drink. Crook is reported to be out here with the Naval Division, but we have not met him yet. Captain Cogan and myself are with the 88th Field Ambulance attached to the 29th Division.

Schlesinger has just returned to us after being wounded, but he was here long enough to do some excellent work, which included tying a carotid in the trenches. We catch glimpses at times of Rivers, another Naval Field Ambulance man. Wacher, Venables and Penn are attached to the 17th General Hospital at Alexandria, we met them as we passed through in April.—Yours sincerely,

J. L M. SYMNS.

Dear Sir,—You invited opinions in your "Passim" of July 17th, and you seem to have stirred up "Dare Quam Accipere." His letter in your last breathes discontent with his present position in every line. I agree with him that the Hospital must be run as efficiently as possibly, and your article did not for one moment suggest anything else. As far as can be made out at present, there is still plenty of room for men in the R.A.M.C. as medical officers to various units in the new army, and when these take the field and go into the firing line, the presence of a surgeon is essential. The first dressings and, in certain cases, urgent operations have to be performed in the zone of fire. When every path, road, house, and wall behind the front line is searched again and again by the enemy's artillery and machine guns, it is not exactly the place where you ought to find the elderly or married surgeon. He should be at the Base or at the hospitals in England.

I think you meant to suggest in your notes that men on leaving Guy's should not join home units, but enlist in the active army. They complain that there is nothing to do and that for weeks on end they are bored to death. I think the letter from H.M.S. *Warrior*, though very amusing, will have a most injurious effect. He writes, "Let me offer my own experience as a warning to those who hope to serve the country by joining the navy," and goes on to detail what he has done professionally. He "doctors" for four minutes a day and is bored. Of course he is, but so is the whole fleet because they haven't had a fight. I think he is in a much worse position than the Angels. There can be no more boring job than twanging harps all day or weeping for every little sin committed on earth. Sins are simply an expression of boredom and a desire for novelty. It is only thus that life on earth is made possible.

I believe it is the absence of opportunity that makes Mr. Scott complain. Surely there is variety to be found in the life afloat. There is always the chance of learning the organisation and inner workings of the navy, and the surgeons will be very busy during an action of any severity. Mr. Scott must console himself with the fact that he is a Temporary Surgeon and thank heaven he is not a Temporary Angel. I expect, however, they are also "on active service," though we do not write to them c/o G.P.O. He must not forget that even Angels get bored, as witness the appalling outburst of Michael and his jovial companions.

It seems that Mr. Scott complains because he is living between the devil and the deep sea. It is generally rather an exciting position and often full of possibilities. Let us hope, however, that Mr. Scott will avoid Michael's end, though I am not at all sure from the general tone of his letter he would not at the present time prefer it. Michael, we imagine, lives on the tenter-hooks is gassed often, and has flames projected in his direction at most unexpected moments. He is probably by now one of *Punch's* Incorrigibles, and would find life in Flanders rather dull if called on to repel a German attack.

The intense interest of medicine and surgery lies in the fact that it is a profession given up entirely to experiment on the most interesting subject man and his baffling complement woman. Mr. Scott finds that his experiments on man are curtailed to four minutes a day and he has been separated from the other animal by what are described as "the exigencies of the service." Naturally, he is troubled, and I sympathise with him, but there is still the Hun.

"Dare Quam Accipere" smacks rather of Tower Hill, and I do not like his tone. If he were what is erroneously called a working man, I can imagine him being satisfied that he was "doing his bit" licking stamps at a base hospital. He would plead that he had a longer tongue and more saliva than many men at the front, but I do not think that excuses him. He should leave his job to an older man who might employ a shorter tongue and more beer. He asks for a letter from the War Office. He has only to turn in on one of his excursions to the West End and he will be granted a personal interview.

HUMPTY DUMPTY.

List ot Unqualified Men on Military Service, August, 1915.

Atkinson, C. H., 2nd Lieut., 18th Battn. Royal Field Artillery.
Barker, H. T., 2nd Lieut., 2/7th Battn. Devon Reg.
*Berncastle, H. F., 2nd Lieut., 3rd Battn. Bedfordshire Regiment.
Biddle, F. J., 2nd Lieut., 3rd Battn. Welsh Regmnt.
Brewer, C. H., 2nd Lieut., 2nd Bedford Regiment.
*Bulleid, A., Lance Sergeant, 28th Battn. London Regiment.
*Carter-Braine, J. T., Sergeant R.A.M.C.T., Second London Casualty Clearing Station.
*Conybeare, J. J., Capt., 4th Oxford and Berks Light Infantry T.F.
Cookes, R. V., 2nd Lieut., 10th South Staffordshire Regiment.
*Coxon, A. C. M., Capt., 1/5th Norfolk Regmnt.T.F.
Crook, F. W., Sub-Lieut., 2nd King's Royal Rifles.
*Day-Lewis, A. K., Lieut., West Yorkshire Regiment.
*Dowling, C. B., Private, 4th Troop, "B" Squadron, King Edward's Horse.
†Elkington, C. W.
Haynes, C. G., 2nd Lieut., 4th King's Royal Rifles.
*Hogben, H. F. T., Lieut. (attached) 2nd Battn. Norfolk Regiment.
Howe, G. H., 2nd Lieut., 5th Battn. London Regiment (London Rifle Brigade).
*Kyle, J., 2nd Lieut. 28th County of London Regiment (Artists' Rifles).
*Laver, C. H., 2nd Lieut., R.F.A., 37th Divisional Ambulance Column.
Lindsay, G. P., Temp. 2nd Lieut., 2nd Border Reg.
Marshall, B. G., 2nd Lieut., 3rd Northamptonshire Regiment.
†Mayer, R. G.
Martin, J. N., 2nd Lieut., Army Service Corps.
†Miller, F. C.
Moore, L. W., 2nd Lieut., 1/5th Battn. Gloucester Regiment.
Powel-Smith, C., 2nd Lieut., Durham Light Infantry
Rand, T. A., Lieut., 2nd Wessex R.F.A.
Sandoe, W. A., 2nd Lieut., 11th Devonshire Reg.
Sawday, A. E., Private, Inns of Court O.T.C Sqdrn.
Steyn, S. S. L., Lieut., 115th Brigade R.F.A.
*Totton, J., Lieut., 2/7th London Brigade R.F.A.(T.)
*Traill, K. R., 1st Lieut., 6th Battn. Royal Berks Reg.
*Watt, N. L., 2nd Lieut., King Edward's Horse.

*4th or 5th year Student. †Rank and Unit unknown

Nursing News.

Matron's Office,
10th August, 1915.

For the first time since the outbreak of war there is no nursing news from abroad. It is true that many have been on leave from France, and we have been glad to see them looking so well, but we hope that the letters every one is so interested to read, will be continued.

Gifts in money and kind are received with pleasure by Matron for No. 26 General Hospital, Etaples. A first bale has been despatched to Miss Suart, containing 12 small cushions, 12 hot bottle bags, 160 small cotton bags (specially requested), 1 air pillow, 12 knitted caps, 2 helmets, 30 pairs woollen socks knitted, 36 pairs machine made socks, 6 pairs operation stockings, 6 flannellette split shirts.

During the week £2 10s. was handed to Matron as the proceeds of a sale which seems to have taken place in a famous building immediately adjacent to the Park (*vide* the following verses) :—

THE "PIG AND WHISTLE."

O, come to the "Pig and Whistle,"
The noisiest tavern in town,
Where the laughter is never-ceasing
And we have no need of a clown.

A "canny" Scot is the hostess,
Of most parsimonious fame;
She'll demand your very last penny,
(But we'd better not tell her name).

Two oatcakes are sold for a penny,
Four biscuits, or cracknells, and cheese.
(The oranges went for two-pence a piece,
But we didn't make profit on these!)

She raises the price of the eatables
When the stock is running low;
So, come early, come early, good people,
Ere the lemon has ceased to flow.

The drinks are exact to the minim
(Because I have charge of these),
And their tariff doth never vary,
Though it may do on biscuits and cheese.

Last week it was pouring "cats and dogs,"
(For Home Defence, I suppose);
So we opened our shop at a quarter to ten
And not until one did we close.

And the night division came pouring in
With an eager, hungry air;
A tooth-mug was clutched in every hand
And all the cash they could spare.

A black-browed woman guarded the till
With a murderous water-pistol.
You are very welcome to eat your fill,
But you mayn't rob the "Pig and Whistle."

Next Saturday, too, we purpose again
To open our high-class stores;
We are hoping, in secret, it may rain;
In fact, we don't care if it pours.

For you realise, don't you, that all this "to-do"
Is to gather huge funds together
For our "Guy's" in France, and its up to you
To keep them in pocket for ever?

Pass List.

Examining Board of the Royal College of Surgeons of England and the Royal College of Physicians of London.

First Conjoint Examination, July, 1915.

Chemistry, Physics and Biology.

L. K. Watson.

Chemistry and Physics.

R. E. Williams. J. Kendall.

Chemistry.

E. Hardy. K. Glaisby.

Biology.

J. G. Barrie. C. H. S. Horwitz.
J. H. Sullaiman.

Final Conjoint Examination, July, 1915.

Medicine, Surgery and Midwifery.

*A. D. Marston.

Medicine.

K. L Bates. J. P. Jones.
*G. D. Gripper. *M. J. T. Wallis.

Medicine and Surgery.

*E. Biddle. *V. E. Lloyd.
*F. A. Knott. *K. M. Purkis.

Medicine and Midwifery.

*G. R. Gotharkar. *C. H. Medlock.

Surgery.

*C. W. W. Baxter. A. F. G. Guinness.
E. W. Bowell. *G. S. B. Long.
*J. E. Clark. W. G. S. Neely.
*J. A. C. Greene. *A. L. Punch.
*F. W. Sheldon.

Midwifery.

E. S. Bowes. P. G. McEvedy.
J. G. Jones. *W. L. Partridge.

University of London.

First Examination for Medical Degrees, Part I.

Inorganic Chemistry, Physics, Biology.

J. V. C. Braithwaite. H. V. Le Vieux.
W. M. Brown. G. Massie.
L. Burvill-Holmes. W. W. Payne.
M. Cohen. W. Remington.
P. Couacaud. *E. N. Roche.
G. Davies. S. Rosenschein.
E. E. D. Gray. C. H. St. John.
H. L. Heimann. G. D. Shaw.
G. Hume. H. W. Southgate.
L. Lyne. ‡W. R. Spurrell.
†R. C. B. Ledlie. J. B. Stacey.

† Distinction in Physics. * Distinction in Inorganic Chemistry. ‡ Distinction in Biology.

Second Examination for Medical Degrees, Part I.

T. G. D. Bonar.
J. A. A. Bouic.
St. G. B. D. Gray.
E. F. Kerby.
E. H. L. Leclézio.
G. F. Peters.
W. Skelly.
E. R. Webb.

Society of Apothecaries.

The undermentioned candidate passed in the subject indicated.

Midwifery.
A. Traill.

Royal College of Surgeons of England.

Preliminary Scientific Examination.

Chemistry and Physics.

A. F. Bartle.
C. C. Becker.
J. B. Gregor.
†H. O. Irwin.
†H. S. Murray.
*F. G. P. Flanders.

†Chemistry only. *Physics only.

University of London.

Exhibitions Examination.

Edward Emile Delisle Gray (St. Paul's School and Guy's Hospital) has been awarded a University Exhibition (*Group I.*).

Books recently added to the Wills Library.

Squires Pocket Companion to the British Pharmacopœia, 1915.
Thomson and Miles Surgery, III.
Leftwich, Index of Symptoms, 1915.
Rawlings' Landmarks and Surface Markings, 1914.
Starling's Principles of Physiology, 1915.
Martindale and Westcott, Extra Pharmacopœia, 2 vols., 1915.
Hutchison and Rainy, Clinical Methods, 1912.
Medical Annual, 1915.
Castellani & Chalmer's Tropical Medicine, 1913.
Morton's Radiology, 1915.
Cunningham's Manual of Practical Anatomy, I., 1914.
Besson's Practical Bacteriology, 1913.

Presented.

Todd's Surgical After-Treatment, 1915. By Mr. A. H. Todd, M.S., F.R.C.S.
Urquhart's Life and Teaching of W. H. Gillespie, 1915. By Mr. Jas. Urquhart.
Lane's Operative Treatment of Chronic Intestinal Stasis. By Sir W. Arbuthnot Lane, Bart., M.S., F.R.C.S.
Adam's Asthma and its Radical Treatment. By Dr. A. F. Hertz.
Journal of Physiology (as published), By Dr. A. F. Hertz.
Archives of the Rontgen Ray (as published). By Dr. A. F. Hertz.
Practitioner (as published). By Dr. A. F. Hertz.

Men attached to the Non-Medical Departments of the Hospital serving their Country Abroad.

Men serving from the Superintendent's Office.—D. W. Furlong, F. Greenwood, S. A. Jones, L. Taylor.

Male Domestic Staff.— —. Burley, F. A. Catchpole, W. Cowie, F. Gillham, H. Mankelow, S. Tiley, J. H. Whitbread.

Works Department.—Single men: A. Coles, W. Franks, H. Harris, E. Lane, T. Neale, S. Start. Married men: A. Addington, H. Archer, A. Baker, T. Baterip, J. Bonest, H. Charles, R. A. Connock, J. Coote, J. Hanson, B. Hennessey, F. Kent, E. Matthews, T. Moore, W. Morris, J. Noble, W. Stuckberry, H. Thornton.

Change of Address.

E. L. Martyn Lobb, c/o Hong Kong and Shanghai Bank, London.

Lieut. H. H. Elliot, R.A.M.C., attached 8th Welsh Regiment (Pioneers), 13th Division, Mediterranean Expeditionary Force.

Lieut. L. R. Broster, R.A.M.C., 34th Field Ambulance, 31st Brigade, 14th Division, British Expeditionary Force, France.

Capt. F. R. Bolus, R.A.M.C., from 5, St. Aubyn Street, Devonport, to 25th Field Ambulance, 8th Division, British Expeditionary Force, France.

F. G. Lloyd (Surg. R.N.), R.M.A. Anti-Aircraft Brigade, British Expeditionary Force, c/o G.P.O.

Capt. H. V. Leigh, R.A.M.C., from No. 22 General Hospital, British Expeditionary Force, France, to No. 42 Field Ambulance, 14th Division, British Expeditionary Force, France.

(The Editor will be very glad to receive a post card with notes of any change of address.)

Births.

BOLLARD.—On June 30th, at "Somerville," Wealdstone, the wife of Julian Bollard, of a daughter.

ODGERS.—On July 30th, at 16, Castilian Street, Northampton, the wife of Capt. N. B. Odgers, M.Ch., F.R.C.S., R.A.M.C. (T.F.), of a son.

REYNOLDS.—At the Bungalow, Royal Avenue, Great Yarmouth, the wife of A. J. Reynolds, L.D.S. Eng., of a daughter.

Marriage.

JESSOP—WALLIS.—On July 26th, Philip Everard Jessop, L.D.S. Eng., Lieut. 2/5th Loyal North Lancashire Regiment, to Charlotte Gladys Wallis, of Forest Gate, Essex.

E. N. G.

GUY'S HOSPITAL GAZETTE.

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Passim.

SERVICE men are nowadays adept at writing their home letters to the accompaniment of musketry fire, bursting of Jack Johnson shells and exploding mines, but we personally have yet to learn how to sit down, calm and collected, and write our Editorial Notes, whilst a glance through the window reveals a white object travelling across the sky, lighted up by searchlights, surrounded by bursting shrapnel, and itself dropping explosive and incendiary bombs. This was our lot on two nights this week, so that we must be excused if our notes do not attain a high standard.

FURTHER on in our columns will be found a list of Guy's men on active service abroad. We are fully aware that this list, which has been preceded by one or two others in previous issues of the GAZETTE, is nothing like complete. But no pains have been spared to try and collect as many addresses as possible, and we sincerely hope that those men who have not sent us their addresses will be spurred on to do so when they notice the omission of their names in this list.

ALL medical students should read the letter, which Professor Halliburton of King's College wrote to the War Office and the reply which he received at the instance of Lord Kitchener. The reply to senior students is at least gratifying, for it bears out exactly what they have been advised to do by the Heads of their Medical Schools and Hospitals, namely, to continue their Hospital work and qualify as quickly as possible. This is the first official advice that has been given by the War Office on this subject since the beginning of the war over a year ago. Frequent appeals have been made from time to time by Medical Students, and now after twelve months, they have received an answer, and yet even this is not a satisfactory one to junior students, for it is ambiguous. Why can it not be expressed in definite terms the course in which their duty lies? However, it is not our intention to discuss this at length in this issue, but we propose to do so in the Students' Number which will appear as usual at the end of this month. For senior students now, their course is marked and they can forge ahead with their work and unhesitatingly sweep aside any unofficial arguments which may be—and they often have been—brought against them in the performance of their duty at home.

YET another announcement has been made by the War Office. Temporary commissions in the R.A.M.C. are to be given to men who apply, after having just qualified. They will then be allowed to hold House Appointments at their own Hospital for three months, after which they must join up to their Army Medical Units. During these three months their services may, however, be commandeered by the War Office at short notice.

It is difficult to see how these measures will improve the rate of recruiting into the R.A.M.C. Medical men at present are in a position to join the Army or Navy whenever they desire to do so, and the chance of donning a khaki uniform for three months after qualifying, before becoming attached to an Unit, is not an attraction which will materially increase the number of men coming forward to offer their services.

Also it is only too obvious, if all newly qualified men only held a three months' House Appointment before going on active service that there would be a far greater dearth of men to carry on the work at Civil Hospitals than there is at present.

AT the beginning of the month the Caterer's Contract with the College terminated. The Clubs' Union have now undertaken the task, and have placed a Manageress in charge of the establishment. The Catering Sub-Committee meet once a week, and they hope that all Members who have any complaints or suggestions to make, will write them down and send them to the Secretary of the Committee, who will bring them up for discussion at their next Meeting.

It will be readily understood that this is a very big undertaking by the Clubs' Union, and one which we hope will meet with success. To ensure this, the co-operation of all Hospital men, including the members of the Staff, is necessary, and we shall be very disappointed if we do not see our feeding rooms better patronised than they have been recently. The benefits which men will derive by taking their meals in the College, are not far to seek, for the Clubs' Union will make use of any profits for supplying meals at cheaper prices, and making all round improvements in this Department.

WE offer our hearty congratulations to Mr. J. G. Saner, whose engagement to Madamoiselle Tanna Denoux was announced last week.

MR. J. H. E. WINSTON, Wills Librarian, has vacated his post, and is now training with the O.T.C. prior to taking up a Commission in the Army. We wish him the best of luck and a speedy return. His place has been taken by Mr. A. E. Morley.

From the Library come complaints that men are taking out books and failing to return them on the same day. This is a very annoying practice, and it is hoped that this "gentle reminder" will cause a lot of these books to be returned.

TO SISTER.—Am sending too you to night too let you know that I am enjoying good health and that I Have has you told me great weakness in my ankles from the weight of my Body has the Blood has not found its proper runs yet. But I trust it will soon be again has before. I am sure that you or the other Nurses will ever forget what a great trouble I was. During the great pains I had to endure. But in the meantime I acknowledge what you Dear Ladies have too endure from the sick when doing your utmost in every way and form too do your best for all may God Bless you all and protect in every way and give you the best of health too. Do for others has you did for me—Yours etc.

OWING to unforeseen circumstances is was impossible for us to publish a GAZETTE on August 28th.

Change of Address.

Lieut. D. Allan, R.A.M.C., c/o Director of Medical Services, Mediterranean Expeditionary Force.

Lieut. F. A. Osborn, R.A.M.C., No. 10 General Hospital, British Expeditionary Force (formerly Clyde House, Dover). Promotion to Captain due 25th August, 1915, not yet gazetted.

Professor H. G. Plimmer. F.R.S., 32, Queen's Road, St. John's Wood, N.W.

Lieut. H. Millett, Deal Battalion, Royal Marines, R.N.D., British Mediterranean Expeditionary Force, R.E.F.

Lieut. R. Manton King, from "Havercroft," Chapel Road, Worthing, to Deaconess Hospital, Alexandria, Egypt.

J. H. Ross, 36, Shaftesbury Road, Ravenscourt Park, W.

Lieut. H. H. Elliot, R.A.M.C., 19th General Hospital, Alexandria.

F. W. Rowland, M.D. (Durham), "Roseg," Borstall Hill, Whitstable, Kent.

E. L. Martyn-Lobb, c/o Hong Kong and Shanghai Bank, London.

Obituary.

DAVID BRIDGE LEES,
M.D. Cantab., M.D. Durh., F.R.C.P. Lond.

We regret to announce the death of Dr. David Bridge Lees, which occurred suddenly on August 16th. He died in harness, for he was engaged in his practice when first attacked.

Born in Manchester, 1846, Dr. Lees was educated at Owen's College, Manchester, and Trinity, Cambridge, and there he had a most distinguished and versatile career as he was a Wrangler, obtained honours in the natural Science Tripos, and distinction in Greek and Divinity.

From Trinity he came to Guy's and held the usual appointments; he qualified M.R.C.S. Eng. and M.B., B.C. Cantab. in 1874.

After having returned to Manchester for a few years, he was appointed Assistant Physician at Great Ormond Street Hospital in 1879, and Assistant Physician to St. Mary's Hospital a year later.

Although Dr. Lees never allowed any particular phase or branch of medicine to take possession of him to the exclusion of disease as a whole, yet his best known work was on the diseases of the thoracic organs; here his powers of all-round observation and skill in eliciting physical signs stood him in good stead.

He laid great stress on the importance of early recognition of myocardial strains and early phthisis when the conditions were open to curative and not merely to palliative treatment. In the Bradshaw Lecture, 1912, he advocated continuous antiseptic inhalations as the best method of treatment in early pulmonary tuberculosis.

Apart from various articles in medical periodicals he contributed sections to Allhult's "System of Medicine" and Allchin's "Manual of Medicine."

Papers by Guy's Men.

Hector Charles Cameron, M.D., F.R.C.P.: Our present position with regard to the prescription of Proprietary foods in infant feeding.—*B.M.J.*, August 21st, 1915.

Owen W. Richards, M.Ch., F.R.C.S.: The pathology and treatment of gunshot wounds of the small intestine.—*Ibid*, August 7th, 1915.

John D. Malcolm, F.R.C.S. (Edin.): Tubo-Ovarian Abscess, intestinal obstruction, and ureteric obstruction. —*Ibid*, August 14th, 1915.

Appointments.

Civil.

E. J. Budge, L.R.C.P. Edin., appointed District Medical Officer of the Cardiff Union.

Charles John Lamb, L.D.S., F.R,C.S. Eng., appointed Dental Surgeon to the Scattered Homes, by the St. Germans (Cornwall) Board of Guardians.

Naval.

Edgar Lionel Elliott, M.B., is now temporary Surgeon, R.N., and is on the Hospital Ship *Somali*. He joined the Navy the day before war was declared.

E. J. Tongue to the *Ganges*, additional for Shotley Sick Quarters.

Royal Army Medical Corps.

Major C. J. Fagge, M.B , F.R.C.S., is seconded while in charge of the Hampstead Military Hospital.

Major A. M. Tubby, 4th London General Hospital, is seconded

Major W. H. M. Tilling to be temporary Lieut.-Colonel.

John Frederick Silk to be temporary Major.

The undermentioned Lieutenants to be Captain:—Richard F. Ballard, E. C. Petley, Leonard Milton, J. B. Clark.

The undermentioned to be temporary Lieutenants:—Frank R. Featherstone, late Surgeon R.N., William Craufiurd McNaghton Dickey, H. W. Drew, C. M. Brown.

Somerset Light Infantry:—E. A. Dawson to be Second Lieutenant.

2nd London General Hospital:—The undermentioned to be Lieutenants—C. D. Edwards and R. W. A. Cushing.

Roll of Honour.

Wounded.

Lieut. H. H. Elliott, M.B., R.A.M.C., attached to the 8th Welsh Regiment.

Mentioned in Despatches.

Surgeon E. G. Schlesinger, R.N. (Howe Battalion), is mentioned in despatches by Gen. Sir Ian Hamilton, from Gallipoli.

The following officer, connected with the medical profession, is mentioned in a despatch from Vice-Admiral J. M. de Robeck, dated July 1st, reporting the landing of the Army in the Gallipoli Peninsula:—Temporary Surgeon W. D. Galloway, H.M.S. *Cornwallis*, who is commended for service in Action.

Representation of Naval Medical Service.

On the motion of the Chairman, Fleet Surgeon Frederick Davidson Lumley, R.N. (ret.) was appointed Representative of the Royal Navy Medical Service on the Council in place of Sir James Porter, K.C.B., R.N., resigned, to hold office until the termination of the Annual Representative Meeting 1917.

An Incomplete List of Guy's Men on Active Service.

MILITARY.

ALSTON, Captain W. E., R.A.M.C.(T.)	82nd Field Ambulance, 27th Division, B.E.F.
ANNESLEY, Captain F. D., R.A.M.C.	Headquarters, 25th Brigade R.F.A., 1st Division.
BARKER, Captain F. A., I.M.S.	100th Indian Field Ambulance.
BOLUS, Captain F. R., R.A.M.C.	25th Field Ambulance, 8th Division, B.E.F.
BROSTER, Lieutenant L. R., R.A.M.C.	34th Field Ambulance, 31st Brigade, 14th Division, B.E.F.
BROWN, Captain Bevan, R.A.M.C.	M.O. 6th North Staffords, 46th Division, B.E.F.
BROWN, Captain T. F., R.A.M.C.	1st Australian General Hospital, Egypt.
CAMPS, Lieutenant B. W. L., R.A.M.C.	St. Julien's Hospital, Lliema, Malta.
CLARKE, Captain H. M., R.A.M.C.(T.)	Military Base Hospital, Rennes, Brittany.
CLAYTON, Lieutenant L. E. V. Every, R.A.M.C. ...	No. 26 General Hospital, France.
COLLIER, Captain H. N., R.A.M.C.	28th Field Ambulance, 8th Division, B.E.F.
DREW, Lieutenant V., R.A.M.C.	1st British Field Hospital for Serbia, c/o British Vice-Consul, Salonika, Greece.
ECCLES, Lieutenant G. D., R.A.M.C.	M.O. 1st Battalion, East Surrey Regiment, B.E.F.
ELLIOTT, Lieutenant H. H., R.A.M.C.	Attached 8th Welsh Regiment, Pioneers, 13th Division, B.M.E.F.
EVANS, Captain H. W., R.A.M.C.	48th Field Ambulance, 37th Division, B.E.F.
FASKEN, Lieutenant N. E., R.M.	No. 1 Gun, R.M.A., Heavy Howitzer Brigade, c/o G.H.Q., B.E.F.
GIBB, Captain C. de W.	55th Field Ambulance, B.E.F.
GODDING, Captain H. C., R.A.M.C.	2nd Battalion, King's Own Lancasters, B.E.F.
GOLDIE, Lieutenant Ellis G., R.A.M.C.	H.M.H.S *St. George*, Southampton Docks.
GREENFIELD, —— Dudley G., ...	No. 10 General Hospital, Rouen.
HARRISON, Lieutenant S. S. B., R.A.M.C.	3rd Field Ambulance, 46th Division, B.E.F.
HENRY, —— C. John, H.A.C.	A Battery, B.M.E.F.
HILLIARD, Lieutenant M. A., R.A.M.C.	No. 22 General Hospital, B.E.F.
HINDE, Lieutenant E. B., R.A.M.C.	1/2nd East Anglian Field Ambulance, 54th Division, B.E.F.
HORTON, Major J. H., D.S.O., I.M.S., D.A.D.M.S.	12th Indian Division, J. E. Force, "D," c/o India Office, Whitehall, S.W.
HUNT, Captain G. H., R.A.M.C.(T.)	2nd London Casualty Clearing Station, 1st Army, B.E.F., c/o G.P.O.
JEPSON, Lieutenant A. C., R.A.M.C.	M.O. Highland Light Infantry, Lahore Div., I.E.F.
JONES, Captain C. E. M., R.A.M.C. (T.)	Attached 1/4th Hampshire Regiment, I.E.F.
KING, Captain W. T. P. Meade, R.A.M.C.	25th Field Ambulance, 8th Division, B.E.F.
LEIGH, Captain H. V., R.A.M.C.	42nd Field Ambulance, 14th Division, B.E.F.
LIEBSON, Captain A. S.	M.O. R.L.I., "C" Force, Army Post Office, Cape Town, South Africa.
MANFIELD, Lieutenant G. H. H.	M.O. 5th Leicester Regiment, Lincoln and Leicester Brigade, North Mid. Div., B.E.F.
MARSHALL, Lieutenant G., R.A.M.C.	No. 2 Ambulance Flotilla, S.H.Q., B.E.F.
MARTIN, Second Lieutenant J. N., A.S.C.	B.A.P.O., No. 2, B.E.F.
MILLER, Lieutenant G. S., R.A.M.C.	24th General Hospital, B.E.F., G.P.O., London, E.C.
MORGAN, O. G.	Millicent Sutherland Hospital, c/o British Consul, Dunkirk, France.
MUSGRAVE, Captain E. H., R.A.M.C....	M.O. Brecknock Battalion South Wales Borderers, Aden, Arabia.
NICHOLSON, Lieutenant C. R., R.A.M.C.	British Military Hospital, att. Serbian Army, Serbia.
NICHOLSON, Major J. W.	1st North Mid. Brigade, R.F.A., 1st North Mid. Division, B.E.F.
PARMITER, B. R., M.B., B.S.	15th General Hospital, B.E.F.

PARRY, Lieutenant J. H., I.M.S.	H.M.H.S. *Glengorm Castle*, c/o Naval Transport Office, Southampton.
PARRY-JONES, Lieutenant O., R.A.M.C.	56th Field Ambulance, 18th Division, B.E.F.
PERCEVAL, Captain J. L., R.A.M.C. (S.R.) ...	59th Field Ambulance, B.E.F.
PICTON-PHILLIPS, Captain W. E., R.A.M.C. ...	M.O. 1st Batt. Welsh Guards, 3rd Guards Brigade, B.E.F.
PRALL, Colonel, S. E., I.M.S.	H.M.H.S. *Glengorm Castle*, c/o Naval Transport Office, Southampton.
RAHMAN, Lieutenant W. R.	1st Batt. 10th Gurkha Rifles, Maymyo, Upper Burma.
REYNELL, Captain W. R.	Australian Hospital, Boulogne.
REYNOLDS, Lieutenant W. L. E., R.A.M.C. ...	56th Field Ambulance, 18th Division, B.E.F.
RICHARDS, Lieutenant J. F. G.	15th Field Ambulance, 5th Division, 2nd Army, B.E.F
RUST, A. B. Wills	Military Hospital, Valetta, Malta.
RYLE, Captain J. A., R.A.M.C. (S.R.)	No. 7 General Hospital, B.E.F.
SCOTT, Lieutenant Donald C., R.A.M.C.	35th Field Ambulance, R.A.M.C., 11th Division, Brit. Mediterranean E.F.
SEABROOKE, Lieutenant A., R.A.M.C.	Rawal Pindi General Hospital, Boulogne.
SMITH, Captain Phillip, M.C., R.A.M.C.	No. 2 General Hospital, B.E.F.
SMYTHE, Lieutenant W., R.A.M.C.	No. 26 General Hospital, B.E.F.
STONER, Captain P. B., ...	No. 95 Company, A.S.C., 27th Division, B.E.F.
STOUT, Captain T. D. M.	No. 2 Medical Corps, N.Z.E.F.
SYMONDS, Colonel Charters J., A.M.S.	Consulting Surgeon to Mediterranean Forces, Malta.
THOMSON, Lieutenant G. Y., I.M.S.	59th Scinde Rifles, F.F., c/o India Office, Whitehall, I.E.F.
TOOTH, Lieutenant F., R.A.M.C.	26th Field Ambulance, 8th Division, B.E.F.
TUBBY, Colonel A. H., A.M.S.	Consulting Surg., Mediterranean Forces, Dardanelles.
WEBB, Lieutenant H., R.A.M.C.	No. 22 General Hospital, B.E.F., c/o G.P.O.
WICKENDEN, Captain Stanley, R.A.M.C.	48th Field Ambulance, 110th Brigade, 37th Division, B.E.F.
WILLAN, Captain G. T., R.A.M.C. (T.)	82nd Field Ambulance, 27th Division, B.E.F.

NAVAL.

BASTARD, Surgeon H. Rowse, R.N.	H.M.S. *Otway*, c/o G.P.O.
BEARBLOCK, Fleet-Surgeon H. J., R.N.	H.M.S. *Invincible*, c/o G.P.O.
BETT, Fleet-Surgeon W., M.V.O., R.N.	H.M.S. *Benbow*, c/o G.P.O.
CARLILL, Surgeon H. B., R.N.	H.M.S. *New Zealand*, 1st Battle Cruiser Squadron, c/o G.P.O.
CHEESMAN, Surgeon A. E. P., R.N....	H.M.S. *Alcantara*, c/o G.P.O.
COCKREM, Surgeon G. B., R.N.	H.M.S. *Botha*, c/o G.P.O.
DENNY, Staff-Surgeon H. R. H., R.N.	H.M.S. *Faulkner*, 3rd Destroyer Flotilla, c/o G.P.O.
FOX, Surgeon W. E., R.N.	R.M.A. *Laurentic*, c/o G.P.O.
HALL, Staff-Surgeon, R. W. B., R.N.	H.M.S. *Lowestoft*, 1st Battle Cruiser Squadron, c/o G.P.O.
HARKNESS, Surgeon A. H., R.N.	H.M.S. *Europa*, c/o G.P.O.
HOLLOWAY, Surgeon G. W., R.N.	H.M.S. *Impregnable*, Devonport.
HOPSON, M. F. Jas.	H.M.S. *Impregnable*, Plymouth.
HUNOT, Surgeon F. C., R.N.	H.M.S. *Exmouth*, c/o G.P.O.
LLOYD, Surgeon F. G., R.N.	R.M.A., Anti-Aircraft Brigade, B.E.F., c/o G.P.O.
MANDEL, Leopold	H.M.S. *Donegal*, c/o G.P.O.
MANN, Surgeon H. C. Corry, R.N.	H.M.S. *Duncan*, c/o G.P.O.
MARRIOTT, Fleet Surgeon H. B., R.N.	H.M.S. *Egmont*, Malta.
MITCHELL, Surgeon D. A., R.N.	Royal Naval Hospital, Malta.
PEREGRINE, Surgeon H. L., R.N.	H.M.H.S. *China*, c/o G.P.O.
PRYN, Dep-Surgeon-General W. W., R.N.	Royal Naval Hospital, Gibraltar.
VICARY, Surgeon V. P., R.N.	H.M.S. *Hecla*, c/o G.P.O.
WILLAN, Staff-Surgeon Richard, R.N.	H.M.S. *Edward VII.*, c/o G.P.O.

Women and Medicine.

THE exigencies of war-time have opened to women many trades from which in peace they were shut out. This has not been to the same extent true of the professions; but the profession of medicine which was opened to them long ago has opened its doors much wider than before. This is not surprising. Medicine is one of the few professions for which war naturally and tragically increases the demand, and the supply cannot be met by volunteers, however willing. The training is too long, and the demand for the fully trained and equipped has been and doubtless will be very great. In consequence, hospitals staffed entirely by women have for the first time been recognized by the military authorities; while at home, posts formerly held by men have been freely offered to women. This position is not likely to be altered in the immediate future, even when the war is over. Some doctors have given their lives already. Many young men who might have become doctors, enlisted instead, and are dead also. Others, once in the army, may very possibly make it their career. There will inevitably be a shortage in the supply of men doctors, while the demand is not likely to be less. Is there any reason why it should not be met by increasing the opportunities of training open to women?

The prejudices, which the women who first sought entrance into the medical profession had to meet, are believed by the general lay public to have disappeared. I have often heard the idea that there is even a remote survival of such views, scouted as ridiculous. And yet, as a matter of fact, the speakers themselves, when pressed, have often admitted a vague feeling that the best and most responsible work—and posts—should be reserved for men. And in the attitude of many hospitals and medical schools this view is only too faithfully reflected. The old idea that the art of healing was essentially "womanly," and one in which the greatest lady should excel,* seems still to require a resurrection.

If, however, women are to make good the breaches made by war, the question of increasing their opportunities for training is not one which can be put off for long; nor should it be decided by every individual hospital solely with reference to its own traditions or its own advantage. The question is one of service to the race itself, and it is this aspect of it which must weigh most heavily with those who have so magnificent a record of service as the medical profession. It is hardly possible to imagine a greater distress than would be caused by a serious shortage here; nor one more likely to increase the influence of untrained or half-trained charlatans on the public mind. In order to combat the astonishing tendency of the human mind to believe that bounding health and perpetual high spirits may readily be secured by the physical absorption of some pill or draught; or by the mental repetition of some miraculous phrase—"I am well—I am great—I am glorious"—science has a laborious and uphill fight. But faith can be used to create instead of to destroy health of body and mind, and the first essential of faith is that the service given shall be the best possible. In order to secure this, the widest constituency should be drawn from, and none excluded except on grounds of inferior efficiency. If women are not competent in certain branches of medicine, it will not be necessary to close the gates against them. Inefficiency will make them close it against themselves.

There is only one factor which may, in professional as in industrial work, create a competition which shall not give to the race the best for its service, but rather bring down the standard of the whole profession; the factor not of efficiency but cheapness. If women were once to consent to a lower standard and worse conditions of work than men, they would do more harm than good. It is the pride of medical women that, unlike their sisters in other spheres of work, they have on the whole resisted all pressure (and the pressure has not always been exactly easy to resist) in this direction. But one can imagine a very unwholesome soreness arising if, after this, when there is so much work to do, and women believe in their ability to do it, opportunities of trainin and of practice should be denied to them on grounds of sex alone. That there will be difficulties of adjustment is certain, and few of us who have grown up and done our best work under one tradition are anxious to see a new one come in, "for we say 'the old is better.'" Nor can an outsider estimate the greatness of the difficulties or the disadvantages of any change. I would only suggest that the question is one too vital and too great to be decided by such considerations. If women, as physicians, had been tried and found so wanting that one could draw a line and say "women can never serve here as well as men," the problem could be settled in a moment. But if some have proved their worth, it becomes the right of the public to demand that for so great a need, efficiency shall constitute the only right to serve, and nothing which keeps out the efficient, or narrows the field of choice, can be justified. The great schools of medicine will be the first to admit—or rather to claim—this high ground for decision.

A. MAUDE ROYDEN.

* We are told that Tristram was brought to Iseult to have his wounds searched "for she was skilled in healing."

Pass List.

Society of Apothecaries.

At Examinations held recently the following candidates were successful:—

Surgery.—A. Traill.

Medicine (Sections I. and II).—R. N. Craig, A. Traill.

Forensic Medicine.—A. Traill.

The Diploma of the Society was granted to A. Traill entitling him to practise in Medicine, Surgery, and Midwifery.

Diagnosis of Ulcers of the Tongue.

CLINICAL LECTURE BY E. C. HUGHES.

Gentlemen,—I propose to consider the various types of ulcer of the tongue which may be confused with epithelioma, for it is a matter of the first importance to diagnose at once and accurately the nature of the ulcer.

Some fifteen years ago it was the habit to regard all lingual ulcers as being possibly syphilitic, and patients were sent away with a week's supply of potassium iodide. At the end of the week, the ulcer was inspected, and the amount of improvement estimated. If there was any improvement, or the ulcer had not got worse, the patient again retired with a further supply of potassium iodide. This drug unfortunately does sometimes cause a temporary improvement in an epithelioma, for it tends to diminish the inflammatory swelling accompanying it. The result in many cases was that the ulcer, being epitheliomatous and not syphilitic, had been allowed to increase its ravages by the length of time the drug treatment had been continued.

If there is any doubt as to the nature of any ulcer of the tongue, and there often is, the correct method is to cut off a portion of the edge of the ulcer after applying a strong solution of cocaine, and to examine microscopically a stained section.

The types of ulcer which may be confused with epithelioma are syphilitic, tuberculous, and dental (or traumatic).

Syphilis.—The chancre occurs very uncommonly on the tongue. I have seen one case only, where it appeared as a small erosion on the dorsum of the tongue with an indurated base. The lesion was so inconspicuous that had it not been for a careful inspection, it would have been overlooked. This erosion type is one way in which the chancre appears, but it also shows itself in the ulcerated form.

Chancres of the tongue are so uncommon that were they to be recognised by their appearance only, mistakes would be frequently made. They are, however, rapid in appearance and accompanied by early and considerable enlargement of the lymphatic glands, draining the affected part of the tongue, and by other manifestations of secondary syphilis.

Secondary syphilis shows itself in the form of mucous tubercles. These are multiple, oval or circular white patches which stand up above the general level of the mucous membrane of the tongue, and the mucous membrane immediately surrounding each patch shows no inflammation. The mucous tubercles on the borders of the tongue however soon become altered in appearance by the action of rough and carious teeth: they lose their colour, and become gray and superficially ulcerated, while the mucous membrane around shows signs of inflammation in a deepening of the normal pink colour. The mucous tubercles on the dorsum and under surface of the tongue as a rule do not alter their appearance, being more protected from injury by their position.

Tertiary syphilis shows itself in many forms in the tongue, but the type of ulcer which may be confused with an epithelioma is the gummatous ulcer. These ulcers may be superficial or deep and originate in gummata. The gummatous ulcer is very seldom a typical one, with a wash-leather slough and "punched out" appearance. It is more often than not on the dorsum, in its posterior half, frequently multiple and accompanied by other signs of syphilis in the mouth and elsewhere. It is generally deep, the size and shape varying considerably, with a sloughy base and prominent raised borders, which are not particularly hard. In spite of apparent extensive destruction of the tongue, there is no limitation of movement, no enlargement of the lymphatic glands, and very few subjective symptoms.

Recently a woman, aged 33, came to my Out-Patients with two ulcers, one on the left border of the tongue, and another on the under surface, nearer the border than the frænum. Opposite each ulcer was a carious irregular tooth. The ulcers were both superficial, with somewhat hard edges and sloughy bases. There was no limitation of the movements of the tongue, and the lymphatic glands were not enlarged. The question was, were these ulcers traumatic (or dental), gummatous or epitheliomatous? It is rare to find two traumatic ulcers or two epitheliomatous; the ulcer on the under surface of the tongue, though opposite a rough tooth, did not come in contact with it, and so probably was unconnected with it. There was a doubtful history of syphilis. The probability was that the ulcers were gummatous. A section was cut from the edge of the ulcer, and showed chronic inflammatory changes and no new growth. Removal of the teeth, and antisyphilitic remedies caused the ulcers to heal within a fortnight. A Wassermann reaction was positive.

The syphilitic ulcer then which is very liable to be confused with epithelioma is the gumma-

tous type; the ulcers of secondary syphilis, which may develop from mucous tubercles are superficial and multiple, hardly ever cause any difficulty in diagnosis, while the chancre is so rapid in appearance and so soon followed by symptoms of secondary syphilis, that it should hardly ever be confused.

Tuberculous ulcers of the tongue are now known to be less uncommon than was thought some ten years ago. The majority of them are complications of advanced tuberculosis of the lungs, but still some do appear to be local manifestations only of the disease. They are situated as a rule on the tip and the anterior part of the borders of the tongue.

There are many types of ulcer, one which is like the ulcer seen in other parts of the body, its surface covered by flabby granulation tissue, the edges somwhat undermined, while in its neighbourhood there may be small yellow points (or tubercles) or even minute ulcers. The depth of the ulcer varies.

Another type is that where the ulcer has formed, as if from the melting away of a part of the tongue. Butlin in his book shows one where the tip of the tongue appears to have been cut off by a knife. I saw one on the dorsum near the tip of the tongue, which looked as if a diamond-shaped piece of mucous membrane and submucous tissue had been stamped out of the tongue.

A still further type is the fissured ulcer on the anterior part of the margin of the tongue. These fissures, which have hard prominent borders, may extend deeply into the tongue and are liable to be mistaken for epitheliomata. The borders of these fissures may be so prominent as actually to present a papillomatous appearance, which makes them still more like epitheliomata. These ulcers are frequently associated with enlargement of the lymphatic glands.

There are other types of tuberculous ulcer which occur as an extension of lupus from other parts. The diagnosis of a tuberculous ulcer is in many cases very difficult, but you will remember in any doubtful case you will at once have a section made from the edge of the ulcer, and you can at once exclude epithelioma.

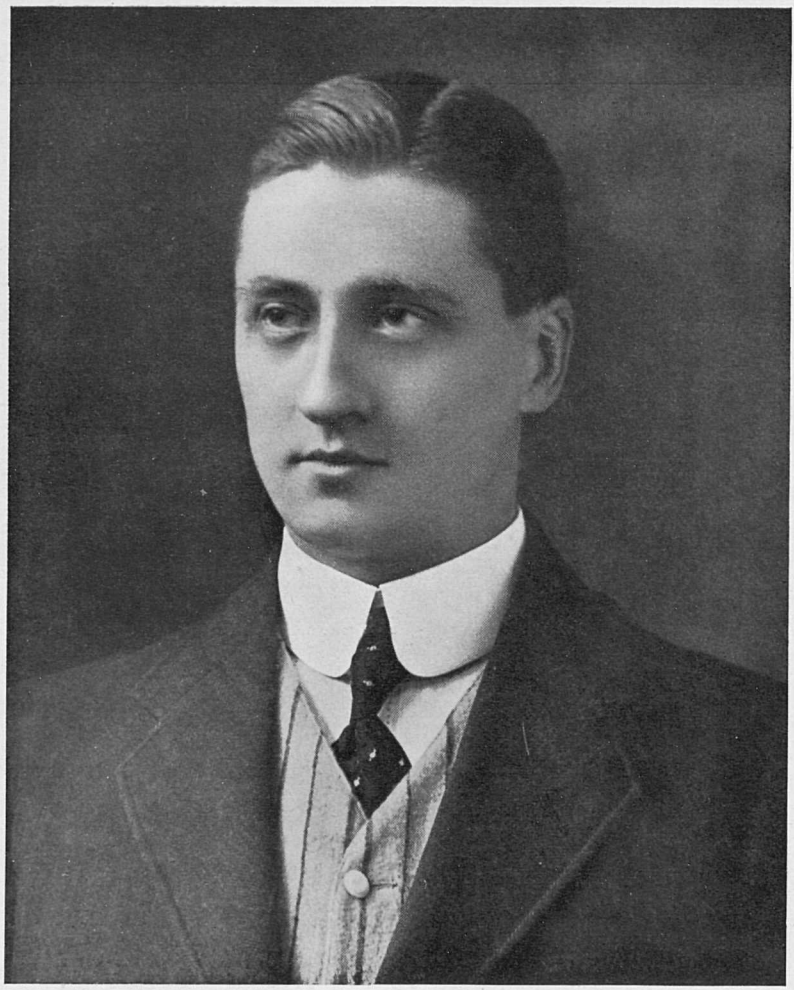
Traumatic, or dental ulcers, are those which arise as a result of repeated damage to the tongue from a carious rough tooth or an ill-fitting toothplate. They are of common occurrence and extremely important, for they are in their chronic stage very difficult to distinguish from epithelioma, and if untreated and the damaging agent be not removed, very liable to become epitheliomatous.

When they first appear, and are in the acute stage, their appearance is characteristic and easy to diagnose. They appear on the border of the tongue, in contact with the damaging agent, the tooth, or whatever it may be. The raw or ulcerated area is not of great extent, it is covered by a thin, grey sloughy layer, the tongue around is swollen, and this swelling extends into the tongue for some distance beyond the ulcer itself, while the whole tongue is covered with fur. Gradually the acute inflammatory symptoms pass away. the swelling subsides to a great extent, and a chronic ulcer remains. The surface of the ulcer is covered by granulation tissue and is of a red glazed appearance, its depth varies but is exaggerated by the prominence of the edge of the ulcer, which is decidedly firm. It is this firmness or hardness of the edge of the chronic traumatic ulcer that makes the difficulty in diagnosis. It not infrequently happens that removal of the carious tooth produces no change in the ulcer, so that the suspicion that it may be malignant is strengthened, but that healing quickly follows upon removal of a portion of the edge for section. This small operation apparently acting as a stimulus to the chronic inflammatory condition.

Epithelioma.—The advanced cases of epithelioma of the tongue offer no difficulty at all in diagnosis, and it is only necessary to consider the early malignant ulcer. The malignant ulcer may occur in any part of the tongue, but is uncommonly found in the posterior third. It occurs more commonly on the borders than the dorsum. It is nearly always the result of some chronic irritation of the tongue, a rough carious tooth, an illfitting tooth plate, a local or generalised chronic superficial glossitis, a scar in the tongue, oral sepsis, etc.

The malignant ulcer is small and superficial at first, but its edge is hard, and the ulcer as a whole is hard. As it extends it eats more and more into the tongue, gradually interfering more and more with the mobility of the tongue. But in the early stages it is the hardness of the edge which will make you suspicious that the ulcer may be malignant, and which will lead you to examine microscopically a portion of the edge of the ulcer. The glands are not at first affected, but sooner or later they become affected. You must remember that the glands may be, and probably are, involved, although you may not be able to feel them.

I hope I have indicated to you how difficult it is to diagnose the nature of some lingual ulcers, that clinically it is often impossible to



Lieutenant H. L. HOPKINS,

(R. A. M. C.),

Killed whilst serving in France, September 19th, 1914.

Qualified at Guy's Hospital. M. D. (London).

Captain MALCOLM LECKIE, D.S.O.

(R.A.M.C.),

Died of wounds at Frameries, August 28th, 1914.

Qualified at Guy's Hospital. M.R.C.S., L.R.C.P.

do so, that the wrong treatment is to see syphilis in every ulcer, and that the right treatment is to examine microscopically a portion from the edge of the ulcer.

Ulcers of the floor of the mouth, other than epithelioma, are very uncommon; epithelioma, on the other hand, is very common, and seems to be increasing in frequency in this position. Why it should be so it is difficult to see, as the floor is protected from injury. Nearly all these cases, however, are associated with an extremely septic condition of the teeth and gums, and I suppose the malignant ulcer in this position is due to the chronic irritation from this source.

About the operative treatment of lingual cancer I only propose to touch on a few points. Though death from the operation itself, even when it involves removal or division of portions of the mandible, is very unusual, yet the mortality of the more extensive operations is appreciable. In nearly all cases the cause of death is sepsis, and in these operations causes of sepsis must be eradicated.

Before the operation the teeth and gums must be treated and put into a cleanly condition: carious teeth extracted, others scaled and filled. Do not be too anxious to save the teeth, particularly the lower teeth, for an edentulous subject offers fewer difficulties in an operation on the tongue than a subject with teeth. The patient must pay careful attention to keeping his mouth clean, in addition, by means of mouth washes: and the surface of the ulcer must be cleansed by antiseptic treatment.

During the operation the greatest care must be exercised to prevent any blood escaping into the larynx; this may be done in many ways, but the most satisfactory is to have the patient anæsthetised by the intratracheal method. When this method is used you need experience no anxiety if any blood escapes into the pharynx, for the outward current of air from the larynx will prevent any blood from entering the air passages. Completely check all bleeding before sending the patient off the table, ligaturing the larger vessels, *e.g.*, the linguals. Finally cover over all raw areas in the mouth by suturing suitable parts of mucous membrane together, for the less raw area that is exposed in the mouth the less is the pain.

The after treatment is often wearisome and difficult when the patient, owing to pain, cannot swallow and cannot tolerate nasal or œsophageal feeding. For the first day or two the patient can be given fluid by the rectum, and then feeding can be begun with great caution. The greatest care must be exercised to see that there is no danger of fluids escaping into the larynx during the feeds.

The wound in the mouth must be continually syringed, to get rid of discharges, and to keep the mouth cleanly. In all cases you will remove the lymphatic glands which correspond to the affected part of the tongue, and this you will do at a second operation.

There is one occasion, however, when you must remove the tongue, and at any rate the submental and submaxilary glandular regions at the same time, and that is when the growth in the mouth, particularly the floor, appears to be directly infiltrating those regions.

A Case of Cerebellar Abscess.

WILLIAM B., æt. 32, a barge builder, was admitted into Addison on July 29th under Dr. French for headache and drowsiness. Patient has had no previous diseases. He is married. Of the six children, two are dead, one of diphtheria, the other of measles. Patient had complained of occasional bad frontal headaches for the last six months, and for some time he has had a discharge from the left ear. Recently he has complained of drowsiness.

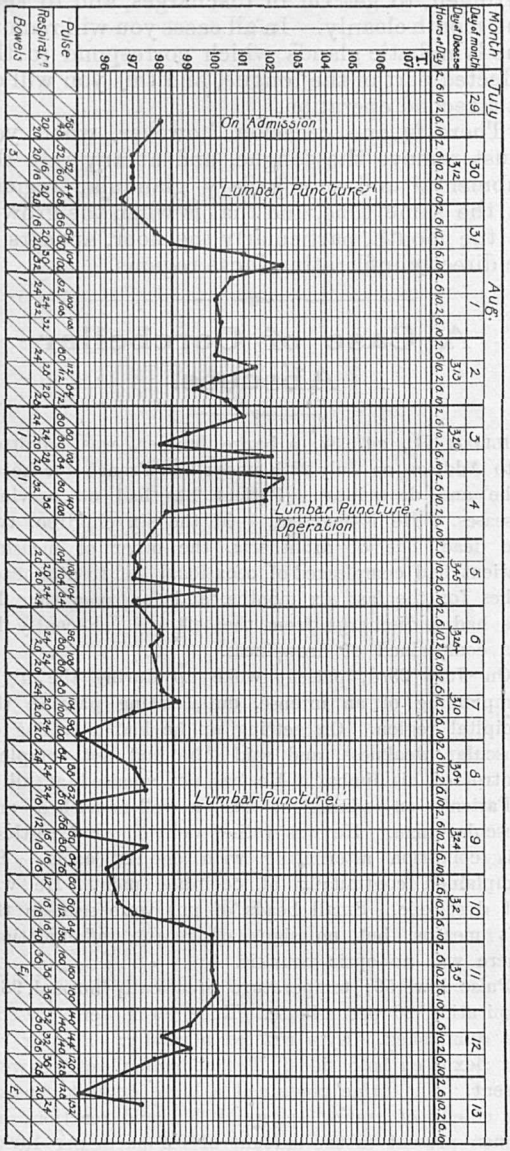
On July 23rd, patient woke up during the night complaining of an intense, dull, aching pain in the occipital region. On getting up he had a feeling of muscular weakness, and said "he had not complete control of his limbs." He has not vomited at all.

Patient, on admission, was a well-nourished and muscular man. He was rather delirious and restless, this condition alternating with one of coma. He complained continually of occipital pain. He was not dyspnœic. Small beads of pus were seen in the left meatus, but no signs of recent inflammation. There was no optic neuritis.

Pulse low, 56; temperature practically normal, 98°; respiration 20 per minute. Knee jerks were present, but diminished. Eyes reacted normally. Plantar reflex flexor on both sides. The abdominal reflexes were absent. The urine contained a large deposit consisting chiefly of urates; sp. gr. 1020; acid reaction; albumen present to the amount of 0·5 parts per 1,000; a few casts were seen microscopically. The respiratory, circulatory and alimentary systems were normal. Blood pressure 130 mm. Hg.

On July 30th lumbar puncture was performed, the fluid escaping being clear and not under pressure. Wassermann reaction negative. In spite of lack of dyspnœa the case was thought to be one of uræmia, pilocarpine, hot air baths, purgation, and saline infusion being administered.

On July 31st patient's temperature went up to 102·4°; pulse 108. Patient was incontinent. Dr. Ryffel estimated urea in blood at 0·38 per litre (normal 0·3).



On August 4th patient was again incontinent and more comatose. Examination of urine showed only a trace of albumen present, with large deposits of urea nitrate and triple phosphate crystals in deposit. Mr. Mollison saw the patient, and on the general condition, the slow pulse, the history of chronic otitis, and the fact that there was marked coarse lateral nystagmus towards the affected side, diagnosed cerebellar abscess.

A radical mastoid operation was, therefore, performed under ether by Mr. Mollison. Pus was found in the antrum, the walls of which were full of small pits containing pus. The dura mater of posterior fossa was widely exposed. The lateral sinus was also exposed. The cerebellar portion of the dura was seen to be red and bulging, whilst the cerebral dura was normal. On puncturing the cerebellar dura about an ounce of foul-smelling pus escaped. This, on cultivation, showed presence of B. proteus. A rubber drainage tube was then inserted deep into the abscess cavity and the antrum packed lightly with sterile gauze.

On August 5th patient seemed much more sensible; he said that he was now completely free from pain. He was no longer incontinent.

On August 6th patient suffered from profuse sweating, alternating with periods of shivering, and gradually became more comatose. Was again incontinent.

On August 8th the right eye was noticed to be deviated inwards. Knee-jerks present, plantar reflexes flexor. There was no evidence of paralysis, but the abdominal reflexes were absent. Lumbar puncture was performed and the fluid came out under slight pressure.

On August 9th Mr. Mollison again saw patient, and found that the dura of the middle cerebral fossa was bulging. He therefore punctured it, drawing off some cerebro-spinal fluid under pressure.

On August 10th patient was comatose, albumen in urine again reached 0·5 parts per 1,000; during the day his pulse rose from 60 at 2 a.m., to 112 at 2 p.m., to 136 at 10 p.m. His temperature was subnormal, except in the evening when it rose to 99·8°.

On August 11th the pulse reached its maximum of 160 and then gradually declined with the temperature until the 13th, when patient died. The wound was dressed twice daily and the abscess cavity syringed out with boric acid.

Autopsy.—The abscess cavity was found to extend throughout the whole left lateral lobe of cerebellum, and contained blood clot. There was a mild degree of hydrocephalus. There was evidence of old healed phthisis at apices of both lungs. There was evidence of nephritis.

Points of Interest.—The albuminuria and casts led to the diagnosis of uræmia. The primarily slow pulse, suddenly rising, seemed to point to meningitis having supervened. The complete loss of headache immediately after operation.

In conclusion, I wish to thank Dr. French and Mr. Mollison for permission to publish this case.

F. DEACON.

Errata.

Page 328.—E. J. Cooke, House-Surgeon Milton Hill Hospital, Steventon, Berks, *not* as Lieut. R.A.M.C.

Page 330.—Mr. H. Muir-Smith *should read* Mr. L. Muir-Smith.

Nursing News.

"In Aid of No. 26 Base Hospital."

On August 26th a concert took place in the Nurses' Home in aid of our Base Hospital, "Somewhere in France." Considering that it was arranged in only a fortnight, and rehearsed usually only from 10 p.m. to 10.45 p.m., a really excellent programme was placed before the audience.

MISS SMITH.

The concert opened with a pianoforte duet of Gounod's by Nurses H. O. Marshall and D. Cox, excellently rendered. This was followed by a sketch entitled "At Cross Purposes," an amusing play extremely well produced by Nurses Cockshott, Brown, Rees, Phillips, Ward, Shorter, and Webster. Nurse Gibson Sugars charmed everyone with her rendering of "Agatha Greene," and Nurse D. Slade, as "Mrs. Murphy on Honesty" (by Barry Pain) left no doubt that she had reduced the reproduction of the Borough to a fine art. The Pierrot troupe, "Some Stars," consisting of Nurses Wellburn, Shepherd, B. M. Edwards, and Thackeray as Pierrettes, and Nurses Sherrin, Price. Adnams, and A. E. Dean as Pierrots, met with a huge reception. Nurse Thackeray, Nurse Wellburn, and Nurse Price sang the solos, while many "home truths" came out in the "topical songs," accompanied by Nurse H. O. Marshall. Miss Langhorne Humphreys and Nurse B. M. Edwards introduced a new dance entitled ? which was much appreciated.

As usual, the violin solos by Nurse E. V. Smith received tremendous applause, and the Irish jig by Nurse C. A. Taylor and Nurse M. G. Rice was just "real Irish," and absolutely charming. Songs by Nurse Wadlow and Nurse S. M. Clements were tremendously appreciated, and Nurse Irene Birch at the piano was a great success.

The concert ended with a "farcical extravaganza" entitled "The Heavy Aunt from California." The dramatis personæ consisted of—Nurse Hella Bell, B.A., who was absolutely priceless as a heavy niece; Nurse Millicent Allen made her a charming frivolous sister; while Nurse Christian Baker was a huge success as the sister who so successfully impersonates the "Heavy Aunt," Nurse Dorothy Cox; Nurse E. M. Humphries, as Nurse West, filled us all with such joy that the play threatened to be held up for some considerable time; however, they got on with it; Nurse C. W. Dean was all that a mother should be; and Nurse Ermintrude Townsend was all that a maid should be.

Coiffures, we believe, were supplied by the famous Orthopædic Department, and furniture was borrowed from anywhere.

Altogether £30 was realized, and with the sale of photographs and verses we are still hoping. Many thanks are due to Sister Marian as Hon. President and Sister Out-patients as a most excellent stage manager.

Verses from the Great Hen Convention.

"HERE WE ARE AGAIN."

The nurses, when the "Change" comes round,
They fairly get the hump,
They feel a weakness in their knees
And in their throats a lump.
The walk along the "Colonnade"
Is like the "Bridge of Sighs,"
But once the "office" safely through,
They'll sing with gleaming eyes:—

Here we are, here we are, here we are again.
There're senior pros. and junior pros. galore.
You can hear them talking
As to tea they're walking,
Are we downhearted? No!
Let 'em all come!
Here we are, here we are, here we are again.
The Sister takes you all in with half an eye.
Here's your book of work, Nurse,
You couldn't do your hair worse,
I can't think why they sent you here again.

Now in the morning early when the bell begins to ring,
You just turn over in your bed,
Or out of it you spring.
You hurry down to breakfast, put your cuffs on as you go,
And when you've all partaken, then the Sister wants to know!—

Now, are we all here? Yes!
That's alright, so long as we're all here—
All the strings, the stripes, and the pros.
All the blue-birds in rows, and rows, and rows.
And so, we're all here? Yes!
Can't hear a word you say.
Is Nurse, Nurse here? eh?
What did you say?
It's her whole day to-day!

"SISTER THEATRES."

Sister Theatres has a garden on the balcony.
She's heaps and heaps of plants and shrubs
And hops in pots and tubs.
'Tis said that Sister Rabbage
Wants the "Park" for growing cabbage.
"Old London Bridge," 'tis said,
She wants to make a mushroom bed.
Should you come to the "Top Theatres"
Nurse whispers "come outside."
Then when you ask where Sister is,
She says with loving pride:—

Sister Theatres watering her garden.
Such aptitude for horticulture
Sister Theatres shows,
She's got a fine "Lane Lily"
And a "Lupin à la Willie,"
A handsome Haughton Hollyhock
And a Cooper-Perry Rose.

Second—
A Saucy Saner Sunflower
And a little Bromley Rose.

MISS SMITH.

"OUR R.S.O."

Our R.S.O. has introduced a heavy antiseptic.
He calls it "Hypochlorus,"
And he thinks it's jolly good.
If used at ops. he tells us that
No wound would dare go septic,
But that, of course, depends entirely
On the surgeon's mood.
Should you go up to Pat. and Sam.
Or Theatres any day,
And listen very carefully,
You'll hear the nurses say:—

Have you met Jack Saner's Hypochlorus?
Its a Topping antiseptic
That our R.S.O. has got,
And a name like Hypochlorus

Rhymes so nicely with the chorus,
But its sad that just a spot of it
Will make six towels rot.

"HOME SISTER."

Sister Marian has got a nasty, nasty habit
Of putting out the lights when you're just
Getting in your bath.
You scramble round to find the soap,
But always fail to grab it.
And when your toothbrush can't be found,
You cannot raise a laugh,
You softly creep back to your room,
The door is sure to slam!
Then when your nightie you can't find
You gently murmur———bother!!!

Home Sister, why will you put the lights out?
We're having such a good time.
Ten to supper on the floor,
The feast is simply ripping,
But around you'll soon be slipping,
And if you put all the lights out,
Well, we can't have any more.

"TO THE RESIDENTS" (who didn't come).

And now we've asked the Residents,
We hope they've all attended,
There's Messrs. Curle and Kendall,
Mr. Holmes and Mr. Knott,
Mr. Jackson and the President.
The audience is splendid,
With Burnside, Richards, Attwater,
And Dr. Dean, what! what!
But to get into the chorus
You must start your name with "S,"
So who they are, of course,
Its quite a simple thing to guess:—

Swilson, Stallman, Scott, and Slambrinudi,
We hope you've all turned up to-night
To listen to this verse,
And if you don't think us funny,
Well, we only want your money,
To send out to number "Twenty Six,"
So kindly leave your purse.

A. EALAND DEAN.

MATRON'S OFFICE,
23rd August, 1915.

The first bale of goods sent out to No. 26 General Hospital has arrived safely. Miss Suart, the Matron, writes, "I do not think that any time will be lost in making use of everything you have sent. We are delighted, too, with the red rubber air cushions."

A second bale will be packed and sent off this week. A special request has been made for old linen and rags to be used as dusters and polishing cloths.

On Saturday, August 21st, a party of ten nurses left Victoria for Boulogne to nurse in the military hospitals, the Misses Adams, Bowdler, Gladstone, Gower, Johnson, Lithgow, McManus, Raven, Richardson, and M. West; and during the last month many old friends have been home on leave for a few days, all looking very brown and well.

Miss Emily McManus having resigned her appointment as Sister Astley Cooper to go abroad, Miss Norah Maher has been transferred from night duty to Astley Cooper, Miss M. E. Hope from the Preliminary Training School to night duty, and Miss Irene McComas has become Instructress in the Preliminary Training School.

Miss Unity Kinsman resigned her appointment as Sister Charity in July, and has sailed for China, where she will be Lady Superintendent of the Foreign Hospital, Tong Shan.

Miss Florence Wittrick was transferred from the Nurses Home to Charity Ward, and Miss Violet Smith returned as Assistant Home Sister.

Miss Blanch Holman, Miss Ada Farrar, Miss Frances Sheldon, and Mrs. Elias (Nurse Templeman) have been helping during the summer as temporary Night Sisters, and Mrs. Hugo, who was Sister Lydia for so many years, has also been doing Sisters' holiday duty on day.

On August 25th Miss Lorna Wood started with a number of Nurses for Egypt, where she has been sent by the Joint War Committee. As far as we know, the other Guy's nurses who have lately gone to nurse in Egypt are Miss Lilian Tyers, Miss Cecilia Pearson, Miss Clara Shann, and Miss Winifred Gillett.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR,—As you see, we were obliged to evacuate Dunkirk. We left on May 10th, when the shelling was at its height. The Hospital was then full of very badly wounded after the first gas attack in the north. It was dreadful having to pack off men with badly fractured femurs, chest wounds, etc., at a moment's notice by trains already crowded from the other hospitals. However, it was urgently necesary, as one hospital had already been hit, with many casualties. Most of the work was done at night, and we found that for the fractured femurs the Thomas' knee splint was by far the most comfortable apparatus if the limb was well fixed with webbing and bandages and firm extension made with cord to the iron piece which projects beyond the oot.

About two months previous to this, we had provided ourselves with a complete equipment for a tent hospital, and having selected our spot at the biggest town on the main line beyond Dunkirk, we started our removal.

Like everyone else under similar circumstances we had an eyeopener as to the amount of material accumulated, but with the help of French and naval lorries everything was soon transported. It took us ten days to put up the tents and commence taking wounded. We worked like niggers in pouring rain and a field like a quagmire, but after six months of Malo it was just what I personally wanted—ten days of hard manual labour, driving in pegs, carrying crates of floor-boards, sleeping like a top and with a corresponding appetite.

Since then we have had an average of 60—70 patients in all the time, and have room for 100—120. Each tent holds either 20 small beds or 16 large ones, and we have a special receiving tent with 12 beds, where the patients are washed and disinfected and their clothes removed for steaming.

The X-ray tent is a great success, with an outer thick brown covering and an inner red one, though we do most of that work at night. The cases have not been so severe as were those we had in Dunkirk, but all the same they are very interesting.

We are very lucky in being in a field just outside the town. The water supply is excellent, and near us is a factory with a first-class engineering workshop. We make our own electric light by means of an oil engine, dynamo, and accumulators, all housed in an old London postal motor bus.

I don't know quite what our plans are for the winter, but most of the country is really too low and wet for tents. I was down in Boulogne two days ago, and saw Starling, Genge Andrews, and Bill Smythe, Reynell spent three days at the camp, and I have also seen Ryle and D. W. John further south. I had the good luck to visit Ypres. It is just like Pompei, every house a ruin, and a sight one is never likely to forget, especially if he has seen it, as I have, full of country people and soldiers, with a market in full swing in front of the Cloth Hall.—With kind regards, yours sincerely,

OSWALD G. MORGAN.

The Duchess of Sutherland's Hospital,
Bourbourg: France, Nord.
August 9th.

Melanuria and Alkaptonuria.

DEAR SIR,—I am desirous, for purposes of coloured illustrations, to obtain fairly fresh specimens of urine from cases of alkaptonuria and of melanuria secondary to melanotic sarcoma respectively. It is difficult to meet with these just when one wishes to, and I should be very glad of the publicity of your columns in case any reader of the GAZETTE may be in a position to let me have specimens of either of the above kinds of urine.

I may add that it is not necessary that the urine from melanotic sarcoma should be itself dark; even if of normal colour it may yet give the chemical tests for melanogen, which is what I require.—I am, yours faithfully,

HERBERT FRENCH.

62, Wimpole Street, W.

"Whitehalling."

AFTER a long and painful ordeal at Queen's Square, I received the "glad hand," and was informed that I was the proud possessor of the sacred letters M.R.C.S. and L.R.C.P. Next morning, having no appetite for the food portion of my breakfast—rather unusual—I made up my mind to call at the War Office to offer my services to my King and Country in foreign lands. Now, whilst I can play a good game of football, and hit a golf-ball as accurately as the majority of men, yet I cannot see anything at all out of my left eye. However, thanks to three months' work in the Eye Wards, I knew the eye chart backwards.

So I set out, and after some little difficulty managed to locate the War Office. With shoulders well set and chest out, I marched up to the front entrance and was politely but firmly told to go round to the back, to the Enquiry Office. I immediately complied, and found myself in a small entrance hall, filled with all sorts and conditions of men and women. The inventor was prominent with a shell under his arm; a tall man with a high hat and frock coat was loudly demanding an interview with Lord Kitchener (an attendant afterwards told me that this was a daily occurrence); officers of all ranks; mothers and wives anxiously inquiring for their dear ones; now and then a tear would fall from a poor woman sitting quietly in the corner waiting for better news.

I eventually succeeded in reaching the important man in the office and told him what I wanted. In return he handed me a slip of paper with the remark, "Fill it in!" After doing so I returned it to him. All these precious documents were stamped and placed in separate piles. One old major cunningly extracted his slip from the middle of a pile and placed it on the top. However, the attendant was "all eyes" (I wished I was) and promptly placed the major's slip at the bottom of the pile and gave the owner such a look—it fairly filled me with fear!!

After waiting some time, my name was called, and, together with five others, I was put in charge of a Boy Scout, who led us through an iron grill, where we were checked by an enormous policeman.

On the way upstairs our guide met several other scouts, with each of whom he had a small chat, much to our annoyance. The last of his friends must have been a particular pal, for we had to wait a solid five minutes whilst they discussed a certain "Billy Williams." In the end, our guide decided that he would give "young Billy Williams a clip over the ear-'ole if he 'ad any more of 'is sauce!"

At last, arriving at another floor, we were each given in charge of another Scout, who told us to wait. After some time my name was once more shouted, and I was told to fill up another form and asked whether I desired Home or Foreign Service. I replied, "Foreign." As my examiner was busily playing with

papers, I took the opportunity of looking round the room and soon discovered the eye-chart, but horrors! it was not the same as the one in the Eye Wards!! However, something had to be done, and that quickly, if I was to get through the test, so I learned the letters as hard as I could. My examiner was ready for me all too soon, and clapping a blinker over my left eye (how unnecessary!), he placed me opposite the chart and told me to read. Result—right eye satisfactory. Transferring the blinker to the right eye, he once more told me to read. I remembered down to the fifth line, but there I stuck. However, metaphorically speaking, I patted myself on the back for remembering even that much!! When the blinker was removed I cast another casual glance at the chart, when, to my disgust, I saw that it had been changed!!!

As I turned to my examiner I noticed his hand on a button, which evidently worked a spring and so altered the chart. Before I had time to explode, my examiner said quietly, "Sorry, we all know how keen you chaps are to get to the Front; but one requires almost three eyes for that. Home service for you, my boy. How much leave do you want? A fortnight? All right; get your uniform ready, we'll advise you when we want you—in about three weeks' time." I retired somewhat disappointed, but happy.

In this article I have called a certain object "the button," if anyone would like to know my opinion of it, I will send it them post free, provided they treat it as confidential. C. H. B.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

The House Fly, a Slayer of Men. By F. W. Fitzsimons, F.Z.S., F.R.M.S. (Longmans, Green & Co., 1915.)

In the first chapter of this work will be found a few preliminary remarks on the means by which bacteria may gain access to the human body, and in the subsequent chapters the Author has demonstrated how the house fly may introduce these bacteria into a house and with what results. He then points out the likely places from which the fly may collect bacteria, and several chapters are devoted to the life history of "this terrible insect" and its breeding grounds, special attention being devoted to those chemicals which prevent the multiplication of the species.

The necessity for protecting foodstuffs from the "*musca domestica*" is strongly emphasised, and finally, to enhance the value of his work, the Author quotes the figures and the attendant beneficial results of an anti-fly campaign, such as was carried out in Johannesburg in 1913.

This little book is illustrated throughout, and no scientific education is necessary for its comprehension. We would strongly recommend it to all housewives in particular, and to all (for there are many) who are not acquainted with the damage which the all too common house fly is capable of doing.

Index of Prognosis and End Results of Treatment. By various writers. Edited by A. Rendle Short. (John Wright and Sons, Ltd., Bristol). Price 21s. net.

This volume forms a companion to the "Index of Treatment," edited by Hutchison and Stansfield Collier, and Dr. French's "Index of Differential Diagnosis." It is naturally impossible to review a work of this kind in any detail, and no attempt will be made to do so.

The selection of contributors is on the whole a happy one, although, perhaps, in some cases men of wider experience and greater authority might have been chosen. Medicine, surgery, gynæcology, and obstetrics are all dealt with, and, as the Editor, Mr. Rendle Short, claims in his preface, a great deal of work has been done in attempting to reach accurate conclusions, not only by a systematic search through literature, but by personal communication with a large number of patients.

The articles on general surgery have been written by the editor himself, and he has collected an interesting and valuable series of statistics, which are well worth perusal. The very difficult subject of fractures is dealt with by Mr. Greer; here again a large number of statistics are given, and an attempt has been made to contrast the results of operative and non-operative treatment. It is wisely indicated that, although the operative method is in many cases the ideal one, the skill and technique of the operator are factors of enormous importance. In fact we doubt whether, in this connection, general statistics at the present time are of much value.

The various sections on medical diseases are on the whole well done, and one instinctively searches for those on nephritis, exophthalmic goitre, acute rheumatism, diabetes, etc., the prognosis of which is so uncertain, yet of such great importance. Mr. Rendle Short is responsible for the account of exophthalmic goitre, and he quotes statistics from various sources, giving the results of medical and operative treatment. We believe that in this country at the present time, as is the case on the Continent and in America, the latter method is gaining favour. In our own experience, although the immediate mortality of the operation has greatly diminished and temporary improvement usually follows, relapse, often to a distressing degree, practically always occurs after a few months, and we are inclined to accept the view of Drs. Hale White and Leonard Williams that the ultimate end seldom justifies the means. We do not doubt that when the disease is more fully understood operative treatment will be found to be based on a false conception of its nature. At the same time it must be admitted that Kochers figures in particular are very striking.

Dr. Poynton has written the article on Rheumatoid Arthritis, and it is no cheerful view that he takes of its prognosis. In this, as in so many other obscure diseases, a more complete knowledge of the normal and abnormal bacterial content of the intestinal tract will probably prove the key to more efficient treatment, and thereby materially change the present outlook. Dr. Arthur Latham contributes an interesting survey of the prognosis in pulmonary tuberculosis, and discusses the main factors to be considered in estimating a patient's chances. Dr. Sequeira'a articles on the more important skin diseases are brief and clear, and the profession will appreciate his remarks on lupus vulgaris, in consideration of his great experience in this disease.

Reference might be made to many other important and valuable sections, but we will content ourselves with drawing attention to the late Sir Thomas Cloustar's survey of mental diseases, to the articles by Dr. Purves Stewart on nervous diseases, and those of Mr. Thomson Walker on surgical diseases of the bladder and kidney.

We have searched in vain, both in the index and text, for an account of osteoarthritis; considering the prevalence of the disease and its obstinacy, the omission is a serious one.

To estimate the precise value of a work of this nature is very difficult. We have always been somewhat prejudiced against the "index" type of book, and we question the advisability of combining medical, surgical and gynæcological subjects in one volume. Surgical prognosis, of course, lends itself well enough to statistical consideration; not so medical prognosis. There the personal element, social status, and surroundings play so great a part. What a fascinating book could be written on this subject by such a physician as Sir James Goodhart! We only hope that he or one of similar experience may be persuaded to do so.

Notice.

Medicsl Students on Naval Service.

Messrs. N. A. H. Barlow, A. W. Cocking, R. N. Craig, H. W. Eddison, J. Stanley Ellis, C, T. Helsham, H. J. Leviseur, and E. C. de M. Morgan.

(All the above are believed to be acting as Surgeon Probationers.)

Specialities.

"Going on fine."

NOT even the amazing cheerfulness of our wounded Tommies can lessen that sadness and that aching sense of helplessness which comes to us every time a khaki-clad convalescent goes hobbling by; indeed, his very cheerfulness touches us the deeper. Not that we have lacked for suggestions; a thousand ways of helping have been fired at us from here, there, and everywhere, many of them more truly hindrances and nuisances than "helps."

But one particular form of help has won such evident appreciation from the Tommies themselves, and has so evidently deserved the praise and gratitude showered on it, that it may be welcome news to many a would-be generous soul to know of it. We refer to that properly famous tonic and restorative known as Hall's Wine.

How splendidly Hall's Wine has helped our wounded warriors we shall never fully know, but the Proprietors themselves have, in the sheaves of grateful letters they possess, a very fair idea, and beyond question many and many a kind sender of this preparation could endorse most heartily the message of these very human letters.

With such plain evidence that Hall's Wine does indeed fulfil its mission as a re-builder of strength and energy, and as a restorer of body, brain, and nerve, its popularity as a gift for the wounded or convalescent is scarcely to be wondered at, and the rapidly growing demand for it is equally understandable.

It is interesting to know, by the way, that Hall's Wine is the original prescription of a well-known West-End Physician—a Member of the Royal College of Surgeons.

Births.

BOWEN.—On August 25th, at Lensfield Road, Cambridge, the wife of W. H. Bowen, M.S., F.R.C.S., of a son,

DENYER.—On August 19th, at Albion Street, Hull, East Yorks., the wife of Stanley E. Denyer, C.M.G., M.D., M.A. (Cantab.), F.R.C.S. (Eng.), of a son.

GARDINER.—On August 26th, at Dunmow, Essex, the wife of Napier Gardiner, of a son.

LEWIN.—On July 31st, at 1, Haling Park Road, South Croydon, the wife of Dr. George Lewin, of a son.

REY.—On August 15th, at 9, Park Road, Bognor, Sussex, the wife of Jules F. Rey, of a son.

REYNOLDS.—At the Bungalow, Royal Avenue, Great Yarmouth, the wife of A. J. Reynolds, L.D.S. (Eng.), of a daughter.

RYLE.—On August 30th, at 15, Madeira Place, Brighton, to Captain John Ryle, M..B, R.A.M.C., and Miriam Ryle, a son.

Death.

LEES.—On August 16th, 1915, David Bridge Lees, M.D. (Cantab.), M.D. (Durham), F.R.C.P. (Lond.), Consulting Physician to St. Mary's Hospital, in his 71st year.

E. N. G.

GUY'S HOSPITAL GAZETTE.

VOL. XXIX., No. 710.] SEPTEMBER 25, 1915. [SIXPENCE.

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Passim.

ONCE again, it is our pleasant duty to welcome recruits to the Medical Profession, and Freshmen within our Gates. In the corresponding issue of the GAZETTE last year, the Editor complained of the difficulties which beset him in delivering this annual sermon. This year they are increased manifold.

However uncertain it was last September to prognose the effects of the War on the prospects of Medicine as a career, to-day it is comparable with a highly complex riddle. The number of men taking up medicine has fallen greatly, so that in five years time the reserve of doctors will be correspondingly diminished. Supposing that the war will have been finished in five years, is the Medical Profession going to enjoy prosperous times?

Commercial prosperity is one of the benefits which a large country reaps after figuring victoriously in a war; moreover, commercial and professional prosperity go hand in hand, so that the question then resolves itself into, "How soon after the termination of the war will England and her Colonies see commercial prosperity?"

This is hardly a question to be discussed here, but it is certainly one which all men, who contemplate entering the Medical Profession, have to consider in weighing up the "pros and cons" of Medicine as a career. In our opinion, the present is so important that the future may be temporarily neglected. The position of a man who enters upon his preliminary course at Medical School this year is not yet definitely established. Professor Halliburton, of King's College, in answer to his letter to the War Office on this subject, received the following reply;—"The War Office would be unwilling to suggest that Junior Students should be discouraged from taking combatant commissions."

We interpret this to mean that if a Junior Student wishes to take up a combatant commission in the Army, then no difficulties must be placed in his way to prevent him from doing so. If on the other hand, he wishes to continue his preliminary course, then his position, for the present at any rate, is assured.

During the last six months it has occasionally been brought to our notice that men have tried to enter the Medical Profession, not with the idea of showing any enthusiasm for their work, or of ever getting qualified, but with a view to safeguarding themselves, should Conscription ever be established in England. Such a course of action is of course despicable, and Guy's has no use for such men, and no pains have been spared to keep them outside our gates.

To our Freshmen, then, we extend a hearty welcome, and would like to offer some advice which will, we feel confident, prove of value to them. First of all they must remember that student life is nowadays very different from what it was a year ago. "Rags" are practically non-existent, and "work" is the order of the day, and frivolities are not countenanced so lightly as of old. The Medical Profession is essential for the well being of the Army and

Navy, and when the record of Medical Service in the present war is written, it will be one of which they themselves will be proud, provided that they have done their duty by it. Their duty is to regard themselves as recruits of the Medical profession and to treat the requests of their Heads in Hospital life as orders coming from a Commanding Officer. They will find that any keenness they may show for their work will be readily seconded by the Heads of the Departments in which they are working.

Further on in our columns, they will find all the details of their future work, but nothing about the different sporting clubs which thrive so successfully in times of peace. This does not mean that football has been "put on the shelf" altogether, as Secretaries are at present arranging fixtures with Schools and Regiments during the coming season, which we hope to publish at a future date. The Clubs' Union Ground at Honor Oak Park will be open as usual, and men would be well advised to go down there for "runs."

The Officers' Training Corps is at present on a "peace footing," but should it burst into activity again we would strongly recommend all Freshmen to seize the opportunity of becoming acquainted with infantry and stretcher-bearing drills.

Finally, we would like to point out to them that, having signed the Register, they become "Guy's men," and as such, we feel confident they will do all in their power to uphold the traditions of their School and add fresh laurels to the name of Guy's.

WE regret to have to announce that Mr. J. G. Saner has been compelled to resign his post as Resident Surgical Officer, owing to ill-health. Mr. W. E. Tanner has been appointed in his place. Mr. Saner has left the Hospital to take a holiday; on his return he will take up the duties of Surgical Registrar.

CAPTAIN A. C. M. COXON, 5th Norfolk Regiment, has been wounded and made a prisoner of war in the Dardanelles. In a letter home he says that he has two flesh wounds in his legs and that he is being treated well by the Turks.

IN our last issue we inadvertently inserted an advertisement paragraph about a Medicated Wine which has been strongly censored in the Report of the Committee on Patent Medicines. We have received several letters of protest from subscribers, and would like to take this opportunity of apologising for the mistake, for which the Editor was alone responsible.

TO NIGGER: A LAMENT.

Nigger, Gentle Nigger—Art truly dead and gone,
And left us but thy shadow to wail and think upon?
No more to see thy blackness lie sunning in the sun!
We miss thee much, old fellow, and are sadder every one!

There are kittens in the Boro';—but none compares in grace,
Nor in leisurely deportment, nor in charming catlike face,
With our Nigger of the College who has softly pined away,
Who has left the College nothing but a very gloomy Gray.

We welcomed thee at dinner; we liked thee in the Park,
Saw thee in the daylight, and heard thee after dark.
Dear old Feline Sportsman; art truly dead and gone,
And left us but thy shadow to wail and think upon?

The Medical Situation.

BESIDES the easily explained fact of the present scarcity of students, there is another phenomenon to be noticed in the Hospital now; and that is, the remarkable quiet that reigns, particularly among first and second year men. One might almost suppose that men in this stage of development had become non-existent. But things have not quite reached such a pitch. Undoubtedly there are first and second year students coyly lurking in the secret recesses of our domain. Why they are not in such sprightly evidence as they were fifteen months ago can be explained in several ways.

First, one may imagine that they are all oppressed by a desire to pass their examinations

in record time. This may be true; and perhaps all work and no play has made them dull. It is a pity, because excessive reading is a doubtful method of learning medicine. There is no profession in which observation and personal practice is more advantageous. To take a concrete example, if one reads anatomy before having done any dissection, one might as well be struggling with an unknown tongue. But, after having dissected, the reading of anatomy crystallises one's observations in the memory. Reading for medical students should be a revision of personal experiences; only to be undertaken seriously two or three months before an examination. It is astonishing how much knowledge may be acquired by simply walking the Hospital.

With this desire for rapid passage to qualification, there goes an increased sense of responsibility that is apt to oppress the mind. The olden time students clad themselves in a fine atmosphere of irresponsibility; though there is nothing to show that they blossomed into less capable practitioners than our present brood seem likely to become. And they were quite on the side of the angels; for a man does not, or should not, undertake responsibilities for the purpose of being overpowered by them. It would be as bad as if a man were to go into battle with the idea of being shot. When the dislike of taking a responsibility has been suffocated, gloom is only ridiculous.

That may be one reason why newly arrived men appear as if under a cloud. Another reason may, perhaps, be the idea that one should be fighting Germans rather than Biology. This is a short-sighted view. Not only are medical men one of the most necessary classes in the country, but science also is too necessary to be slighted by our stupid conscriptionists. To join an army that is already so unwieldy that it cannot be properly equipped is almost criminal while there is such a need for doctors. If an army lives on its stomach, its stomach lives by doctors. It will be argued that any shortage of medical men will be compensated by the numerous lady doctors, now threatening us with invasion. The public, however, has a distrust of lady doctors that will take a great effort to dispel. If one considers that, ever since the beginning of history, woman has been dominant in the household, one may understand that, perhaps, when, in the course of another million years, she has scientifically discovered both the full nutritive value of foodstuffs and the proper means for obtaining it, then she may suggest an excursion into other realms. With very few exceptions, lady doctors are too apt merely to copy men, though they do not know it.

But we are leaving our subject behind us. The third reason for our comatose condition is perhaps the most likely one. And that is, the appalling cut-throat competition that prevailed long before the war, and is, in fact, disturbing all professions and classes. There is too much of the survival of the fittest in the medical profession, and we are in danger of applauding the survival of the most brazen. It is a tremendous factor in damping high spirits, and does not offer a prepossessing outlook. A general practitioner stands comparatively isolated, and has to depend upon his own efforts to rather too great an extent. If the profession were more of a corporation, things would be better; and, indeed, there is no reason why a body such as the British Medical Association should not expand until all medical men are organised into a national service after the manner of the Navy and Army. The experience of the Insurance Act shows its possibility, and it is an idea that deserves consideration.

J. A.

Roll of Honour.

WOUNDED.

Lieutenant-Colonel A. R. Wilson, M.D., R.A.M.C., 3rd Welsh Field Ambulance (T.F.).

Lieutenant G. B. Pearson, attached to the Bucks Yeomanry.

Books Received.—The Hospital, Nursing Times, Prescriber, St. Mary's Hospital Gazette, Polyclinic, St. Bartholomew's Hospital Journal, New York State Journal of Medicine.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

In the Eastern Counties.

The night lamps all were lighted,
We slept without a fear,
When a bomb-shell broke the silence,
And it sounded very near.
The lights went out, the cry went up,
"The Zeppelins are here!"

The men assembled on the roof
(Oh, not to "do a Guy"),
But when the enemy's about,
They like to see him fly.
Night Sister shouted, "Come and help."
They answered, "Bye and bye."

The "Blues" all rushed on duty
With aspirin in their hand,
To soothe their timid patients,
And implore them not to stand.
"Oh, do not be afraid," they said,
"We have *two* pails of sand."

The patients shook a weary head.
"'Tis very hard to hear
Them bombs a'dropping all around
And poor us lying here.
We may feel cold, but pray behold
That we have got no fear."

The Nurses all in darkness sat,
Their's was a sorry lot;
The basement is quite free from air,
They found it very hot.
But 'tis well known, when bombs are thrown,
One must be "on the spot."

The Maids behaved with fortitude;
To drown the booming gun
They tripped it to a rag-time,
And defied the flying Hun.
(The Laundry Maids were lectured well,
In case they thought it fun.)

And now at night we're startled quite
If someone murmurs "hark!"
We do not stop to listen,
But we hurry to the Park,
To find we're not the only ones
Who're peering through the dark.

Papers by Guy's Men.

A. P. Beddard, M.D., M. S. Pembrey, M.D., E. L. Spriggs, M.D.: Observations upon the Acidosis in Diabetes Mellitus.—*Brit. Med. Journ.*, 11th September, 1915.

Montagu F. Hopson, L.D.S. Eng., F.L.S.: Apes to Modern Man.—*Brit. Dent. Journ.*, 15th September, 1915.

The Course of Some Recent Cases of Lobar Pneumonia.

THE cases referred to are those which have come in under Dr. Beddard during the past three months. With one exception all the patients have been children between the ages of one and ten. Out of twenty such cases there have been no fatal results. Twelve have been apical and eight basal; empyemata have developed in three cases, one apical and two basal. Pneumococcal septicæmia, as shown by a temperature swinging between 103° and 97°, has followed in four cases; in one, the pneumococcus was demonstrated in the blood, in two cases the blood was returned as sterile, and in the fourth the report has not yet been made.

In two of the cases of pneumococcal septicæmia the temperature came down by crisis, and remained normal for two or three days; a swinging temperature was then recorded, but the patients seemed none the worse, except for the fact that they became somewhat irritable. In the other two cases, owing to the presence of a mixed infection, the temperature was always of an oscillatory nature; it began to descend by lysis and then, when the mean daily temperature had fallen about a degree, the swinging type of temperature commenced. In all four cases the pneumonia was apical.

The one adult in this series presented several features of interest. When admitted on Sunday evening, he was drowsy and irritable, lying curled up on his side and complaining of intense frontal headache; he had vomited twice during the day. The temperature was 104°, the abdomen retracted, and Kernig's sign well marked. There was a faint trace of albumen in the urine. Lumbar puncture was performed and 40 c.c. clear fluid escaped under pressure. (This fluid was afterwards returned as sterile.) A provisional diagnosis of pneumococcal meningitis was made.

On Monday morning he felt better; fine crepitations could be heard along the right border of the sternum; in the evening the right chest was distinctly hyper-resonant. On Tuesday the right chest was dull in front at the lower part and hyper-resonant behind. On Wednesday the lung was dull at the base behind and in front. The temperature fell by crisis on the eighth day.

On examination of this series of cases the invasion of the lungs by the pneumococcus seems to differ from that of other years in the following points:—

a. Low mortality.

b. High percentage of cases showing pneumococcal septicæmia (16 per cent.).

c. Comparative frequency of empyema (12 per cent.).

Some Experiences in Brussels during the War.

By AN OLD GUY'S MAN.

V.—SOME EPISODES.

THE BATTLE OF EPPEGHEM.

After two days and nights of incessant cannonading, a cannonade which, commencing from the thump, thump of individual guns, rose to a continuous roar of artillery that convulsed the town, the inhabitants of Brussels became very curious to know exactly what was taking place outside. Of news there was none; even the German affiches refused to give us any account of what was going on. For, although the gallant Belgian army failed in its objective, namely, to prevent the placing of seige guns before Antwerp, they inflicted such losses on the Germans that the "Kommandantur" did not care to talk about it.

We crowded on the high housetops and scanned the horizon, but the result was very disappointing; save for the horrible din and the never-ending stream of broken men and horses in the streets below, one would never have imagined that the surrounding country-side was the scene of a sanguinary battle. Some of the more imaginative minds saw shells burst, but I think they were misled by the little puffs of steam which rose periodically from a factory in the middle distance and which was still working. By night it was more interesting. We could see an occasional rocket, and the horizon was dotted with the glare of burning villages. But we wanted stronger meat than that to satisfy our appetite for sensation, so some of us determined to attempt to get through the guard lines and view the battle from closer quarters. It was a dismal failure. We were turned back, even before we had passed the Plaine de Schaerbeeck, by the fat Landsturm guard who swore horribly at us in German and brandished their bayonets.

That evening, whilst sitting in a café, I met two intrepid souls who announced their intention of running the gauntlet next morning, and I begged to be allowed to go with them. One of these men was a Swede and the other a Portugese, but both of them had passed a good part of their lives in Germany, and could not only speak the language fluently, but could speak the dialects almost as well as their mother tongues.

We started out on our venture at 6 o'clock next morning (it was a Sunday), and walked by a roundabout way until we reached the Chaussee de Vilvorde. We met with no interference until we had almost reached the town of Vilvorde, and then we encountered a picket. They were, naturally, rather surprised to find civilians so far outside the proscribed boundary, but my friends explained that we were a party consisting of two Germans and an American who had been given special permission to see what we could of the operations, and they backed up their statement by production of a document (of what nature I could not determine) which seemed to satisfy the soldiers.

My companions spent some minutes in chaffing the sergeant in his own special dialect, and he seemed to be immensely amused and pleased. As my knowledge of German is very thin, indeed, I deemed it better to keep my mouth shut. He also gave us our direction, and at the same time warned us not to attempt to pass if we were stopped by a second picket, and especially not to venture farther than a certain copse which he pointed out.

So we started out again, taking care to keep away from the high road, which was literally blocked with troops and vehicles of all sorts, and very soon we came across the gruesome evidences of the battle. We entered a small hamlet, or rather the remains of it; there was scarcely a house or cottage intact, and the smoke was still rising from the gutted buildings. About 200 yards to the right, was a church surrounded by a coppice, but the roof had fallen in, and the remains of the spire was cocked on one side, giving it a ludicrously drunken appearance.

And all this was caused not by shell fire, but by the wanton destructiveness of a few soldiers who had passed that way. As for the inhabitants, we were unable to guess at their fate. Whether they had escaped or whether they had fallen victims to the German craze for stage effect; for the Germans would consider a ruined village very incomplete as a war picture without the addition of a slaughtered peasant here and there. But we came across no evidence of the killing, only the appalling stench from one tumbled pile of bricks led us to believe that the owners of the house had found their graves under their shattered home. It was a pitiful sight, and we were glad to leave it behind us.

Farther on, in one of the small roads leading from the main street of the village, we came across a country wagon tilted into the ditch. Its contents, which were obviously the household gods of some villager, were littered over the road and every bundle and package had been opened. Of the owners, again no sign; but four empty wine bottles on the way-side showed that the pillagers had not gone away empty. Round the bend of the road our progress was blocked by a dead horse, supine, with its feet stretched up to heaven. Evidently the motive power of the unfortunate wagon, but, as the beast was old and decrepit, the soldiers had, in their lust for slaughter, blown out its brains.

Another hour's hard walking and we reached the top of the hill from where we hoped to see something of the battle. It was a dreadful disappointment. As

far as the eye could reach, stretched the flat country. On the crest of the next rise was a blazing village. Probably a repetition of the one we had just left, but never a sign of a man or a gun. On the left we espied the copse of which the sergeant had spoken, and to the left of that we saw the only part of the battle that we had the fortune to see that day. It consisted of intermittent puffs of smoke in the sky, which broke and spread into rings and drifted away. We could distinguish above the constant rumble of the guns the sharp whip-like report of the explosion, and we realised that we were watching shrapnel.

It seemed so far from the copse that we thought we could venture there in safety, and started for it at the double, but hardly had we reached the outskirts when our way was barred by five soldiers, the leader of whom demanded our business there. My companions started their explanation, but the officer would have none of it. He ordered us to return to where we came from at once, and, as there was nothing left to do but obey, we started for home.

One of my companions, who seemed to know the country thoroughly, suggested that we should keep along the crest of the hill until we reached the canal road. By so doing we should avoid the depressing sight of the ruined village and perhaps get a more interesting view of the battle. On descending the other side of the ridge we came suddenly on a small chateau. Curiously enough, it seemed to be quite intact, and we wondered how it had been missed by the soldiery who rarely negelcted anything that could be destroyed or looted.

At first we thought the place deserted, but as we entered the gates we heard someone singing a popular Belgian air. In the courtyard we came upon the singer, a young officer of the German medical service. He had made himself very comfortable in a lounge chair on the stone terrace, and for the sake of extra ease had divested himself of his helmet and boots and was wearing a pair of morrocco slippers. By his side lay a pile of music and with his hand he was beating time to his song. Truly an incongruous sight in the midst of such happenings.

His song ceased abruptly when he saw us, and he stood up in evident surprise at seeing three civilians at such a time. "Where have you come from?" he asked in excellent French. We told him our adventures at the copse, at which he laughed heartily. "Yes," he said, "most of my visitors have come from that copse, feet foremost," and he pointed to the open gate of the courtyard, through which we could see rows on rows of stretchers, most of them empty, some still occupied by wounded men. "Very few remain now, and they will all have left to-night," he continued; "but yesterday and the day before," he made an expressive gesture with his hands, "and they all came from that copse."

It appeared that the copse, our copse, marked the limit of the Belgian shell zone, and a company of German soldiers who were hidden there had caught it pretty badly. The place was still full of unburied dead. That was why we were not welcome there.

I was curious to know why he let the wounded remain out of doors when there was such a fine large house at his disposal. He replied that it was his cousin's house, and he did not want it littered up with such cattle. He wasted his trouble, for next time I passed that way the chateau was roofless and gutted.

"See!" he continued, "they have already spoiled the garden," and he pointed to one end where the shrubs were trampled. In a corner near the wall lay a heap of torn and stained uniforms and near by a pile of boots and accoutrements.

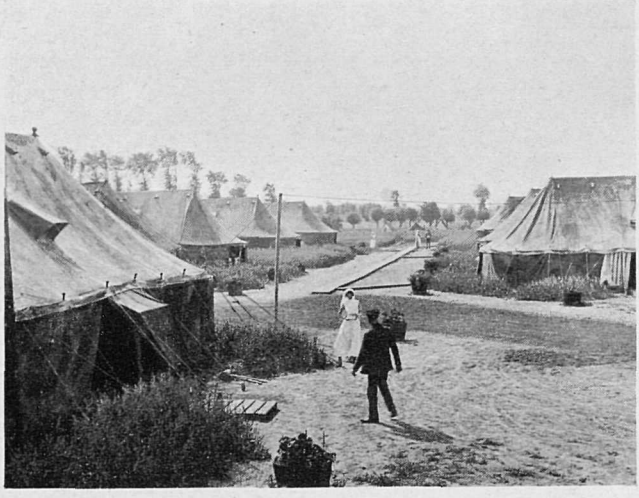
We asked him about the ruined village, and what had happened there. He replied that the soldiers had done that because "someone must have given the Belgian artillery information about the copse, and that that was the nearest village."

Personally, he considered the war a nuisance as it interfered with his occupations. In ordinary times he did not practise his profession; he was a musician, and at the outbreak of the war had been studying singing at the Brussels Conservatoire. The sights and sounds of war offended his refined nature. But half an hour after, we caught him brutally kicking one of his wounded charges because the unfortunate man had vomited on his sacred terrace. It was now well into the afternoon, and we were anxious to be back in Brussels before dusk; so we bid the musical medico "adieu." He counselled us to keep to the high roads, as the by-paths were likely to be full of the gentle German soldiery who considered murder and highway robbery as part of the science of war.

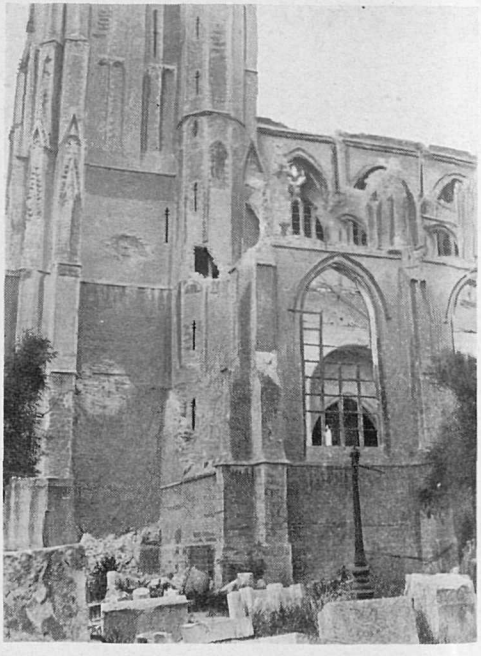
Within an hour we were back at Vilvorde without any exciting adventures, and from there we struck out along the main road for Brussels. On those few miles of road between Vilvorde and Brussels we saw scenes which are beyond my powers of description. It would need a Zola to do them justice. The centre of the road was occupied by a long procession of artillery caissons, ammunition waggons, empty ambulances, and troops of all sorts, all coming from Brussels. Down either side came the backwash from the battle, returning to Brussels. There were ambulances literally crammed with wounded; here and there a maimed hand or foot protruded from under the canvas. These were interspersed with farm carts and hay wagons all loaded with the same horrible harvest. Occasionally one of these would stop, and a dead man would be dragged out and laid by the roadside; his place would be immediately filled by one of the maimed wretches who crawled after the carts begging for a lift.

The Cathedral at Ypres.

A Street in Ypres.

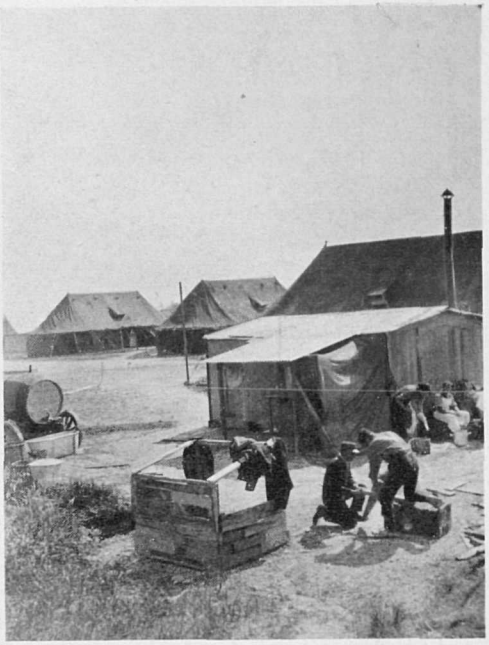


General View of the Camp.

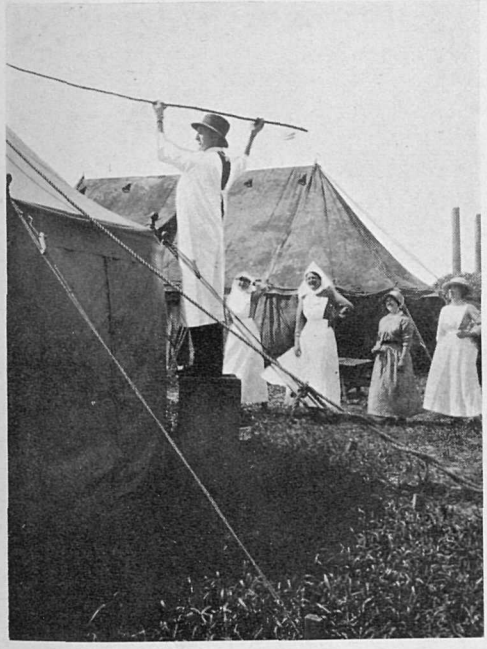


A Church near Ypres.

The Operating Tent.



The Patients' Kitchen.



Painting the canvas for protection against Aeroplanes.

Part of the Camp.

FROM BELGIUM.

By Mr. O. G. MORGAN.

In between the vehicles were groups of wounded men still able to walk, their white faces masked with dust and sweat. Here and there one would drop out, and, if there was no room in the carts, he would be literally kicked into the ditch, there to remain with his fellow unfortunates, alive and dead, until an ambulance party thought it worth while to drag him out. There were men stupified and silent, others drunk and noisy. Sometimes little parties of peasants would pass, old men, women, and children, staggering under bundles containing all that remained of their ruined homes. They were hustled and insulted on every side, but seemed to be too terrified to realise what was taking place.

In the whole procession we did not see one young woman. They had been carried off by the soldiery, and there was no doubt about their fate. Once a motor car passed us. It contained a German officer and two soldiers. The officer was raving mad, and struggling wildly with his companions who were endeavouring to hold him down on the seat. We saw several such cases before our journey was over. A little farther on we came upon a wagon which had lost two wheels, and had scattered its human freight across the road, where they were trampled upon and kicked and cursed by their companions.

And the medley of noises was almost as terrible as the sights. A pandemonium of groans and blasphemy, the rumbling of wheels and the hideous yells from the madman in the motor, and above all the thunder of the guns, a sort of perpetual accompaniment in one key. As we approached the town our progress became slower and slower, and eventually we decided to leave the road and risk the passage across the fields. We re-entered the town near Laeken, and, beyond the usual challenge by the guard, we had no difficulty in passing the barrier. My companions hurried off to see the wounded arriving at Schaerbeck, but for my part, I had had quite enough of the glories of war for one day.

—AND AFTER.

A few days after, when the seige of Antwerp was well under way and there was nothing more to fear from the Belgian army as far as Brussels was concerned, the German government ordered the resumption of the tram service to Vilvorde and gave permission to the townspeople to visit the scene of the late battle.

This time I went with a party of bona-fide Americans. We provided ourselves with passes from the Kommandantur, and set out in an over-crowded tram to Vilvorde. From there we continued on foot in the direction of Eppeghem. The Germans had "cleaned up" the place a bit, but there remained sufficient evidences of the fierce struggle. It was one vast scene of desolation, not a house nor a building of any sort remained intact, and the whole plain had the appearance of having been swept by a hurricane. In some places entire villages had collapsed like a house of cards and not a single wall remained upright.

The Flemish roads were never notable for their smoothness, and three days' heavy rain and the passage of thousands of troops and guns had made them quite impassable. The trees that bordered the roadside had been cut through and through by shot and lay across the road, some had been cleanly pierced as if by an auger, and once we found a shell which had failed to explode and remained imbedded in the tree. The fields on every side were scarred by German trenches and field works, the emplacements of the heavy guns were very apparent, and some of them still contained the curious wicker baskets constructed to hold three shells.

In the early days of the battle the Germans had commandeered hundreds of casks and barrels, and we speculated as to what use they would make of them; but here we found them buried end up in the ground, where they formed a formidable obstacle to any cavalry or infantry charge. There were also a large number of deep pits planted with pointed stakes. The heavy rains had filled these pits half full of water, but here and there the legs of a horse or a military boot stuck out above the surface.

On every side we saw newly-made mounds, some of them twenty yards long, which at first we imagined to be some form of earthwork, but as we approached them the overpowering reek of chloride of lime quickly explained their nature. In some cases the work of burial had been very hastily done, and in one spot, where the rain had washed away the light soil, protruded a leg, green with decomposition, and still clothed in the grey trouser of the Belgian grenadier.

One of the most curious sights was a wrecked fire escape standing alone in the middle of an orchard. It had been cut neatly in two by a shell, and the top half, still attached by the ropes, hung over at a giddy angle. At the commencement of the engagement the Germans had borrowed all the fire escapes from the town to serve as observation posts and artillery direction stations. Another oddity was the quantity of dead birds in the trees, presumably killed by the concussion of the shells. When one shook the trees, their bodies fell in small showers.

Everywhere the ground was strewn with broken rifles, wrecked wagons, and odds and ends of uniforms and accoutrements. With the idea of acquiring some souvenirs, we had selected a few small objects, including a grenadier's knapsack to carry them in, but we were stopped by a German sentry who swore at us furiously and made us empty our booty on the field. One of my companions was fortunate enough to conceal and bring away two projectiles known as "boite aux balles," a kind of shrapnel without an explosive charge, but which burst and scatter their contents on impact with any object.

At length we decided to return. One of the sentries advised us to leave before dusk, pointing out that it might prove unfortunate for any English-speaking person if he fell in with one of the many parties of soldiers who were constantly passing that way. On the road back we passed through one of the ruined villages, where we saw a number of peasants at work extricating the remains of the unfortunate villagers from their cellars.

Nursing News.

MATRON'S OFFICE,
23rd September, 1915.

All will be glad to hear that Matron is very much enjoying her holiday, dividing the time between Scotland and Ireland, and having the same lovely weather as Londoners are at present enjoying.

There is little or no news from abroad. All who have been over on leave look wonderfully well, and their appearance advocates the healthiness of hut and tent life. We hope with the autumn they will remember that it is not the least part of their duty to keep friends at Guy's informed of their doings. Everyone does want to know what everyone else is doing in nursing work at home and abroad. When the lanterns are lit, please remember the GAZETTE, and post "your bit."

Miss C. S. Simpson, who joined the Colonial Nursing Association during the summer, has arrived safely at Singapore General Hospital. She sends a view of the hospital, a long, two-storied building with the familiar deep verandahs, beautifully situated, overlooking the golf course.

Miss Ames writes:—"All the Barge Sisters have been changed. I arrived here, No. 6, to-day, 10.9.15. It is a camp hospital, and just outside a beautiful old town. There is a great pine forest behind us stretching for miles, and we are on a hill with a beautiful view of the town and the lovely hills beyond. No. 5 and No. 9 General are close to us, and in the plain between us and the town are twelve other hospitals, all in tents or huts. There are many other camps round us belonging to different regiments, so we are a very joyous crowd. There are 750 beds in our hospital, all in tents, but we sleep in huts. I think for the winter they are better than tents; they are not so damp, and besides have a little window as well as the door. I am glad to get back on to a big staff again, but enjoyed the barge experience.

"On my way here I had a lovely motor drive to No. 2, where I slept for the night. There I saw Sister Lear. I left early next morning, and by frequently changing trains managed to get here by 11.30 p.m. The trains stopped at every station and very often in between as well, but life on a barge has given me a taste for that rate of travelling, and I rather enjoyed it. It was so very amusing to watch the people at the country stations—their anxiety to get on to the train the moment it stopped, although it never moved for ten minutes.

"There was a most obstreperous baby in the carriage part of the time, who would insist on walking up and down, chiefly on the very clean boots of some officers who did not seem to appreciate it much. So it was a relief to many when our journey ended."

Miss C. Pearson says:—

Red Cross Hospital,
Giza, Cairo,
August, 1915.

"At present I am working under the Red Cross two miles out of Cairo, and we have been most frightfully busy, patients coming in every day and others being moved on. I was in a military hospital at first, and did transport duty.

"About a month ago I met Nurse Percy in Cairo; she was having a short holiday.

"At the hospital in Alexandria Mr. Venables was in charge of my beds.

"It is very hot here, and the Nile is rising, which makes it very damp and uncomfortable and not too healthy. We shall soon have passed through the worst months, and we have really stood it very well."

Maternity.*

IT is said that the glory of war is the wretchedness of its most broken man, and true it is. "All thoughts to rive the heart are here." Ah, but beyond these thoughts and broken lives, what of the multitudinous lives lost to earth for ever? Humanity to-day sees in this appalling devastation a great and threatened danger to its continuity. The torch of life must pass from hand to hand, and as the strong and young man lays it down, who shall carry the light forward? "The children," says our world, looking eagerly around. "they shall be 'for ever England.'"

It is demanded that all child life shall now be zealously guarded, and the babe to be must enter upon a heritage of health and opportunity. The words, "falling birth rate" are suggestive of dull statistics, but the crusade of the privilege and sacred duty of maternity will inaugurate a new era. These things come not at our bidding, as all men and women workers for medical and social reform know full well. The very desolation of war which cries for the healing

*Maternity: Letters from Working Women. G. Bell & Sons. 2s. 6d. net.

power of young and vigorous life will also retard and destroy the advancement, slowly and painfully made, in the struggle of the ages for the life of the child. It is useless to recount in a medical journal the annual toll of 100,000 babies dead under one year, or to enlarge upon the splendid efforts made by the Local Government Board, Town Councils, and private enthusiasm to save and protect these helpless lives. Its readers are those whose life work it is to remedy such loss and to labour in and out of season by organisation and ordered effort to defeat the formidable foes, disease and dirt, ignorance and superstition.

But the lay world has yet to learn that it is its brother's keeper, and if the lack of air and food, cleanliness and decent habitation cause the death of one child, none can escape blame.

That this class-blindness is present is typically and curiously revealed in the speeches, pubilshed this month, of an ex-Viceroy of India, a man of position, ability, and culture, who confesses that of the men, women, and children who *are* London, "I know so little, but wish I knew more, the London of the submerged millions, that baffles and bewilders." He would like to see a clean sweep made on the south side of the river in order that that unknown wilderness might be made "beautiful and accessible." But Southwark is already the home of hundreds of men and women; to whom, then, shall it be made accessible? Could not the words be reversed, and beauty made accessible to the dwellers there?

"Maternity: Letters from Working Women" (the book at present under review) should shed some light upon the complexity of this subject, and it deserves to be widely read. The Women's Co-Operative Guild addressed to a number of working women a short letter in which the following questions were asked:—

1. How many children have you had?
2. How soon after each other were they born?
3. Did any die under five years, if so, from what cause?
4. Were any still-born?
5. Have you had any miscarriages, if so, how many?

Four hundred letters were received in reply, and of these one hundred and sixty are published in this book, with a preface written by the Right Hon. Herbert Samuel, M.P., late President of the Local Government Board. As Mr. Samuel says, "these letters give an intimate picture of the difficulties, troubles, miseries, sometimes the agonies, that afflict many millions of our women as a consequence of a normal function of their lives. An unwise reticence has prevented the public mind from realising that maternity among the working classes presents a whole series of urgent social problems.

"It is necessary to take action to solve the problems that here stand revealed for the elementary reason that a nation ought not to tolerate widespread suffering among its members which can be obviated." Also, "under existing conditions we waste, before birth and in infancy, a large part of our possible population; this is mainly due to ignorance, malnutrition, and to all the noxious influences that go with poverty—evils that are remediable."

Mr. Samuel continues: "The infant cannot, indeed, be saved by the State; it can only be saved by the mother. But the mother can be helped and can be taught by the state.

"The local health authorities have large powers.

"As President of the Local Government Board, I was able to submit to them a comprehensive scheme of assistance to mothers in pregnancy, in confinement, and in the care of infants, and to offer to such as chose to adopt it, a Treasury grant of one-half of the small expenditure involved.

"The need at the moment is to create among local councillors and their electors a body of opinion which will secure the adoption of this scheme.

"Because I believe it will conduce to that end, I commend this book the more readily."

To turn to the letters: they are left exactly as written by the women, spelling and punctuation only corrected. They are simple statements, often dignified, singularly uncomplaining, and very reticent. They are from the more fortunate working-class mothers whose husbands' wages are about 30s. per week, and who have the initiative to attend guild meetings and endeavour to improve their surroundings.

The general impression that the reader gets of the life at such times of the working-class mother is one of perpetual over-work, illness, and suffering. *This is especially the case during the time of pregnancy.* The women themselves acquiesce in the popular opinions of their class that suffering must attend motherhood, and the letters reveal an unbelievable amount of daily torture endured while work is continued and children of various ages cared for.

"Does God make mothers out of victims, then,
And set such pure amens to hideous deeds?"

The ante-natal clinics proposed under the scheme are indeed required. As one woman writes, "it is more knowledge and help that we need." A second makes the statement, "the trouble is that it takes so very long in England for things to be changed." Another says, "ignorance has more to do with suffering than anything."

The tragic waste of pre-natal life in the large number of miscarriages reported is startling, and the subsequent ill-health of the mothers. Few, if any, seem to know that at such a time rest, care, and medical attention are necessary.

Of the actual confinement little is said. A certain number of the writers evidently feel that their poverty obliged them to submit to inferior medical help or ill-trained midwives, but their sufferings are not enlarged upon, they are accepted. These mothers cannot write

of a "twilight sleep" of alleviation. Oh, to be that man or woman who discovers the tree, the leaves of which can be used for the healing of the mother in travail.

The hospitals are barely mentioned in these letters, only one writer suggesting "a State Maternity Home (not the Workhouse) where we women might go at such times for attention and rest." They know only too well they must remain at home to cook and clean, stand at the wash-tub, and care for the other children, and lay out the weekly money. If work at factory or shop is prohibited, the unpaid work of the home always goes on.

All speak with gratitude of the 30s. maternity benefit. Thanks are due to the Women's Co-Operative Guild for their agitation in securing the inclusion of the maternity benefit in the Insurance Act, and in 1913 an amendment making the benefit the mother's own property.

The Guild proposes a splendid national scheme to secure effective care of maternity and infancy, and, working in conjunction with the Local Government Board, *the women who are concerned,* and the medical profession, a new day should dawn for working-class motherhood. Countless infant lives will be saved, now of immense value to the state, and that high human activity, maternal affection, will be unfettered by the pains and penalties of extreme poverty and suffering.

In return for life, can the Nation offer the mother less? "When dying, she said, 'pray for me.' He could only cry, 'My mother, my mother.' It was a full prayer and left nothing unasked of Mary's Son." S.

Appointments.

Medical School Appointments.

OCTOBER–DECEMBER, 1915.

Dressers and Clerks in Special Departments:—

Throat and Ear, Genito-Urinary, and Children.—Messrs. F. N. Sidebotham, G. E. Kidman, B. E. Jerwood, T. E. Micklem.

Throat and Ear, Skin, and Orthopædic.—Messrs. R. H. C. Pryn, G. E. L. Simons, P. D. Chapman, N. H. S. Maelzer.

Eyes and Nervous System.—Messrs. M. C. Joynt, R. R. Traill (Mr. Eason); E. N. Glover, H. I. Sterne Howitt (Mr. Ormond).

Obstetric Dressers and Externs.—Messrs. M. Pearson, I. R. R. Brogden, A. M. Ahmad, W. Burridge, E. C. Morgan (Mr. G. B. Smith); M. B. M. Tweed, E. S. Phillips, H. J. Bensted, I. Tewfik, L. S. Gathergood (Mr. Chapple).

Medical Ward Clerks.—Messrs. S. M. F. Underhill, C. St. L. Campion (Dr. Hale White); J. O. R. Montocchio (Dr. Shaw); V. Ramirez (Dr. Fawcett); R. Aspinall Stivala (Dr. Beddard); W. R. G. Hearnden, C. G. Coombs, J. R. Cox, A. Magill, S. T. Wong, W. A. Hawes, J. C. Gie, S. M. M. Jabir, F. J. Harrington.

Assistant Surgeons' Dressers.—Messrs. E. F. Deacon, R. Leblanc, W. J. Walters (Mr. Fagge); J. A. Berry, L. Gill, H. D. Apergis (Mr. Rowlands); E. H. Bryant H. N. Pritchett (Mr. Trethowan); G. R. Hubbard, R. Millar (Mr. Hughes).

Surgeons' Dressers.—Messrs. A. W. A. Davies, J. T. T. Forbes, E. de Robillard (Sir W. A. Lane); J. F. Carter Braine, G. W. Heckels, C. L. Odam (Mr. Dunn); L. B. Moore, T. L. Heath, S. Vidot (Sir A. Fripp); J. M. H. Campbell, H. St. H. Vertue, H. E. Bamber, J. A. M. Alcock (Mr. Steward).

Surgical Ward Clerks.—Messrs. C. M. M. Armstrong, T. Fernandez, L. S. Debenham.

Student Demonstrator of Pathology.—Messrs. F. Leblanc, E. N. Glover.

Student Demonstrator of Anatomy.—W. H. Grace.

Civil.

Lockhart Stephens, M.R.C.S. Eng., of the White House, Emsworth, Hants, has been appointed Deputy-Lieutenant for the County of Hampshire.

Naval.

To be temporary Surgeon:—W. P. Vicary, to the *Victory*, additional.

Military.

Edward W. H. Shenton, to be Radiographer to the Hampstead Military Hospital on May 7th, 1915.

Major C. H. Fagge, F.R.C.S., to be Temporary Honorary Lieutenant-Colonel and to remain seconded while serving Hampstead Military Hospital, on July 28th, 1915.

M. E. Ball, M.B., B.S., to be Temporary Lieut., R.A.M.C.

Royal Army Medical Corps.

W. L. Marshall, J.P., to be temporary Lieutenant-Colonel whilst employed with the Huddersfield War Hospital.

The undermentioned temporary Lieutenants to be temporary Captains:—H. L. S. Griffiths, W. Henderson, S. S. Crosse, A. J. Eagleton, M. Stott, L. H. Y. Stephen, O. R. L. Wilson, E. H. Griffin, T. S. Allen, V. Townrow, C. Weller, Geo. Elkington, J. L. Stewart, H. A. Pallant, C. Aldis, C. E. Hibberd, V. F. Soothill, E. Billing, E. W. Strange.

The undermentioned to be temporary Lieutenants:—C. A. E. Ring, J. Walker, P. R. Boswell, L. G. Nash, F. O. Stohr, G. Haycraft.

Attached to other Units:—G. B. H. Jones, E. E. B. Landon, London (City of London) Field Ambulance; Captain E. P. Minett, from the Territorial Force Reserve, to be Captain.

The following have relinquished their Commissions: H. P. Costobadie, R. D. Passy.

On Acidosis.

CLINICAL LECTURE BY E. P. POULTON, M.D.

GENTLEMEN,—The term "Acidosis," when used clinically, is usually applied to those cases in which acetone bodies are produced in the organism, and consequently appear in the urine. It is obvious that this is too narrow a meaning for the term acidosis, which can be, and is often, applied to the presence of any unusual acid in the urine. For instance, after muscular exercise, it has been shown by Dr. Ryffel that lactic acid appears in the urine in considerable amounts; this is also a case of acidosis—a lactic acid acidosis. There are several other instances of abnormal acids being produced in the organism, and producing marked effects, but in many cases little or nothing is known as to the nature of these acids; we only infer that they are present. All those many clinical conditions that are embraced by the term uræmia are probably cases in point. However, beyond mentioning that these other types of acidosis exist, I shall say no more about them, but shall confine my attention to those cases in which the acidosis is produced by the acetone bodies.

The acetone bodies are three in number—aceto-acetic acid, β-oxybutyric acid, and acetone. Here are two chemical equations which illustrate at a glance the relationship of these bodies:—

$$\underset{\text{Aceto-acetic acid.}}{CH_3,CO,CH_2,COOH} + 2H = \underset{\beta\text{-oxybutyric acid.}}{CH^3,CHOH,CH_2,COOH.}$$

$$\underset{\text{Aceto-acetic acid.}}{CH_3,CO,CH_2,COOH} = \underset{\text{Acetone.}}{CH_3,COCH_3} + CO_2.$$

The first equation shows that β-oxybutyric acid is formed by the addition of two hydrogen atoms to aceto-acetic acid. This reaction and the reverse change have been shown by feeding experiments and by other means, to take place readily in the body. It is a reversible reaction, and when these bodies are formed in large quantity they are found in the urine in a constant proportion, *i.e.*, the ratio of β-oxybutyric acid to aceto-acetic acid is seven to three.

The second equation indicates that aceto-acetic acid readily breaks down into acetone, especially if the urine is heated.

In the first place, I want to consider the tests, that are commonly used by you in a case of diabetes, for example, to determine whether acidosis is present or not. And here, at the outset, we come across a mistake, that you will find repeated in most of the text-books, but which was exposed by Hurtley two years ago.

There are two ways of performing the nitro-prusside test—(1) Legal's method, which consists in adding sodium nitro-prusside and soda to the urine, and subsequently adding glacial acetic acid, when a dark purple colour develops if the test is positive. (2) Rothera's modification, where the urine is saturated with crystals of ammonium sulphate; sodium nitro-prusside is added and then ammonia; you get a more intense purple colour, and the test is rendered many times more delicate than with Legal's method. Finally, there is the ferric chloride test, which is often called Gerhardt's test. On adding ferric chloride to the urine a brown or port wine colour is obtained.

The latter test is regarded rightly as a test for diacetic acid, and here I should like to point out that the name diacetic acid given to this substance is incorrect; it was given by Gerhardt many years ago, under a misapprehension as to the constitution of this acid. The correct name, *i.e.*, the name corresponding to the true formula of the acid is aceto-acetic acid, and it is by this name that I shall speak of this substance. It is a pity that the incorrect name for this acid should have been perpetuated in medicine.

You will find in most books that both nitro-prusside tests are regarded as tests for acetone; this is only correct if it is realised that they are also tests for aceto-acetic acid (diacetic acid), and further, what is a particularly important point, they are much more delicate tests for aceto-acetic acid than they are for acetone, *i.e.*, twenty times more delicate. Hence in reality, when you get a dark purple colour with either of these tests you are only justified in saying that either acetone or diacetic acid, or both, are present in the urine; you cannot discriminate between them, by this test alone.

However, there are other chemical methods of distinguishing between these two substances, and the results are of considerable interest. Let us get quite clear what the problem really is. You have a urine from a case with slight acidosis that fails to give a positive ferric chloride test, and only gives a positive Rothera's reaction, which you will remember is much the most delicate test. Does this reaction mean that acetone or aceto-acetic acid are present, and if both are present, which is present in excess?

Several investigators have shown independently that if the urine is fresh it only contains small quantities of acetone, and that of

the substance which gives the nitro-prusside reaction, about 90 per cent. is aceto-acetic acid and 10 per cent. acetone.

If the urine is kept, and especially if it is decomposed, the aceto-acetic acid disappears completely, being broken down into acetone. It is well known that aceto-acetic acid is a very unstable body.

In all cases of acidosis, the mild cases as well as the severe ones, it is aceto-acetic acid that is present in greatest quantity, and any acetone that is present will probably have chiefly originated from the break down of the aceto-acetic acid after the urine has been passed.

These observations are opposed to the statement that you will sometimes come across, viz., that in diabetes, when the acidosis is mild, only acetone is excreted, while in more severe cases aceto-acetic acid also makes its appearance, and in the severest cases of all the three bodies are present together—acetone, aceto-acetic acid, and β-oxybutyric acid. This statement is entirely wrong. In any case of acidosis acetone is only present in comparatively small amounts in the fresh urine. Again, β-oxybutyric acid, so far from only appearing in the severest stage of acidosis, is probably always excreted, even in the mildest forms. Unlike aceto-acetic acid, it is a body that cannot be detected by some simple colour reaction, and in earlier work was probably missed altogether, but a much more delicate means of isolating it, has been devised independently by Shaffer and Kennaway, and it has in consequence been observed in quite mild cases; in fact, it is always present when aceto-acetic acid is present. To sum up, in all cases of acidosis the urine contains aceto-acetic acid and β-oxybutyric acid, but acetone is only present in quite small amounts.

So far we have only discussed the urine in acidosis, but before considering the underlying pathological causes, it would be as well to enumerate the conditions in which acidosis occurs.

Conditions causing acidosis.

Health.—Starvation; diet of fat and protein; sudden change of diet and surroundings (Frew).

Disease.—Diabetes mellitus; febrile conditions; gastro-intestinal disturbances, including pernicious vomiting, cyclical vomiting; post-anæsthetic acidosis; cachetic conditions, such as advanced malignant disease.

This list suggests at once something concerning the underlying cause of this condition, viz., that acetonuria occurs in conditions where there is a deficiency of carbohydrate metabolism in the organism.

But you must be quite clear that these substances are not themselves formed from carbohydrate. They are probably formed from fat, and possibly from protein too. Here is a possible explanation. When fat is oxidised under normal conditions, the long carbon-chained fatty acid molecule breaks down two carbon atoms at a time. These two carbon atom groups are fully oxidised to CO_2 and water. For this process to continue, there must be at the same time an oxidation of carbohydrate. The two processes, oxidation of fat and oxidation of carbohydrate, are linked together. If there is a deficiency of carbohydrate, instead of the fatty acid molecule being broken down and oxidised at once, there are excreted groups of four carbon atoms, and these appear in the two forms β-oxybutyric acid and aceto-acetic acid.

The application of this theory to explain acetonuria in cases of acidosis is not difficult. In starvation, carbohydrate is largely used up in the first day or two, and so there is later abnormal fat metabolism. The same thing occurs when there is persistent vomiting, for this is really the same as starvation, as the food cannot be absorbed; in fever owing to the high temperature the body metabolism is increased, while food is usually given in smaller amounts than usual: this is again relative starvation. In diabetes there is certainly plenty of sugar in the organism, but it cannot be utilised, and so it is useless to prevent the abnormal fat metabolism, and so acidosis occurs.

The group of cases described by Frew is of some interest. This observer found that 62 per cent. of children admitted into the wards at Great Ormond Street showed the presence of aceto-acetic acid in their urines, by Rothera's test. The total number of cases examined was 662, and the nature of the disease did not make any difference to the proportion of cases that showed acidosis. Simple surgical cases showed the same phenomenon. The acidosis appeared twenty-four hours after admission, and disappeared by the fourth day. The same kind of patient showed no acidosis as an out-patient. The hospital diet was not deficient in carbohydrate; however, the administration of dextrose soon stopped the acidosis. The explanation seems to be that the change in surroundings and the change of diet temporarily caused an impairment in the absorption of carbohydrate, though the simplest of carbohydrates, *i.e.*, dextrose, could readily be absorbed.

These results bear an interesting relation to post-anæsthetic acidosis. If a child, the day after admission to hospital, spontaneously shows acidosis, which is further increased by what is practically starvation in view of operation, and which is further increased by the effect of giving the anæsthetic, there is not so much to wonder at in the comparative frequency of cases of post-anæsthetic acidosis.

I have now come to a part of my subject which has been worked out comparatively recently, and so is at present little known. Its importance lies in the fact that it affords explanations of the various phenomena met with in acidosis, particularly the air hunger of severe diabetes, as well as abnormalities in respiration occurring in other pathological conditions.

This work is based on a theory which is now generally accepted. This theory is sometimes called the theory of Neutrality Regulation. It seems to be a general rule in biological processes that the reaction of the fluid in which the process occurs has a definite and constant reaction, which may be acid or alkaline or neutral, according to the process. For instance, in the small intestine the reaction is alkaline, and the degree of alkalinity is extraordinarily constant, and the same in degree as that which is most favourable to the various enzyme actions occurring there.

The theory of neutrality regulation states that the reaction of the blood remains constant and neutral under all conditions of life. But here some further explanation is necessary because the blood in the organism itself varies according as it is in the arteries, veins or capillaries. Venous blood contains more CO_2 than arterial blood, and so its reaction is more acid. Hence when one talks of neutrality regulation, one means that the reaction of the arterial blood remains constant under all conditions. The importance of this fact will be evident, if you think of the arterial blood as supplying nutrition to all the vital organs of the body.

Now measurements of the arterial blood in man have shown that the blood is not quite neutral but is very slightly on the alkaline side of neutrality, but it is so very nearly neutral that it may be called so for all practical purposes.

Now how is this neutrality regulated? In other words, in the acidosis of carbohydrate deficiency, where there is a production of aceto-acetic acid and β-oxybutyric acid which circulates in the blood, how is the body going to keep its blood neutral? Theoretically there are three possible ways, and each of these ways is used by the body. In the first place the kidneys are called into play to excrete as much acid as possible in the urine. It is a well known clinical fact that the acidity of the urine in diabetes and in other conditions of acidosis is much increased. In the second place the body could manufacture a base to neutralise the acid, and the neutral salt thus formed could be excreted. The base actually formed is ammonia, and the amount of ammonium salts excreted in the urine is much increased in consequence. In the third place the blood could get rid of some acid that it contains normally and so compensate for the increased quantity of aceto-acetic acid and β-oxybutyric acid it contains.

The acid actually got rid of is the CO_2 and this is what is meant when we say that alveolar CO_2 pressure in acidosis is abnormally low.

The significance of this diminution of the CO_2 in the alveolar air will only be apparent if it is considered with reference to the blood circulating through the lungs. As you all know, under conditions of health the partial pressure of CO_2 in the alveolar air is constant, viz., about 5·5 per cent., which corresponds to a pressure of about 40 mm. of mercury. However, there is a moderately wide range of variation in different individuals, viz., from 4·6 to 6·3 per cent., and in women and children the values are on the average rather lower than in men.

This degree of constancy of the alveolar CO_2 content is brought about by the respiratory movements. In other words, the CO_2 given off from the venous blood is not allowed to accumulate in lungs, but is washed away at a constant rate by the respiration. If the respiratory movements become deeper the washing-out process is more efficacious and the alveolar CO_2 will fall.

Now, it has been shown that the arterial blood contains CO_2 at a pressure equal to the CO_2 pressure in the alveolar air; in other words, the venous blood arrives at the lung, gives off CO_2 and becomes converted into arterial blood and leaves the lungs in equilibrium with the pressure of CO_2 in the lungs. This means that when you deepen your respiration you diminish the CO_2 in the alveolar air, and you *ipso facto* diminish the CO_2 in the arterial blood, which again means that you are depriving the blood of acid.

Now, it is firmly established that acid is *the* stimulus to the respiratory centre, and so we have an automatic arrangement for diminishing the blood acidity, for the acidity increases the respiration, which itself lowers the alveolar CO_2 which then causes a diminution in the acidity.

These considerations fully explain the clinical condition of air-hunger in severe diabetes. In this condition there is present in the blood an excess of aceto-acetic and β-oxybutyric acid. Imagine, as a result, the blood getting slightly acid. This acid blood will act on the respiratory centre which will cause the respiratory movements to be increased, the alveolar CO_2 will be lowered, and the blood will become less acid. Hence the respiratory centre acts as a self-regulating mechanism in keeping the blood as near the neutral point as possible.

Further, the increase in the respiration, or what comes to the same thing, the fall in the alveolar CO_2, gives a measure of the amount of foreign acids in the blood.

The acidosis that arises from conditions other than diabetes, is usually slight. By this I mean that the output in the urine of aceto-acetic acid is small, because there is not much circulating in the blood, the ammonia output is small, and the alveolar CO_2 is only slightly diminished.

Take, for instance, a normal individual on a diet containing no carbohydrate :—

Acidosis due to protein and fat (E.P.P.)

Day of Diet.	Ammonia Nitrogen, gms.	Acidity of Urine. c.c. $\frac{N}{10}$ acid.	Total Acetone Bodies, gms.
I.	0·71	394	0·004
II.	0·83	474	0·923
III.	1·02	536	1·000
	Normal Diet.		
	0·70	337	0·004

The amount of acetone bodies excreted on a normal diet is very small, and requires a special method for its accurate determination. However, on the third day of the diet containing no carbohydrate, the amount excreted rises to 1 gramme. Similarly the ammonia is increased by about half of its normal value, and the acidity of the urine is increased.

Here is another experiment that will show you the behaviour of the alveolar CO_2 during three days' starvation, followed by two days in which cream alone was eaten, cream, of course, being practically pure fat and water.

Diet.	*Alveolar CO_2. per cent.*
Normal ...	5·72
Starvation, 2nd day ...	5·08
" 3rd day ...	4·67
Cream, 1st day ...	4·53
" 2nd day ...	5·00

You will see that the alveolar CO_2 falls gradually and reaches a minimum value on the third or fourth day and then slowly rises again. This seems to indicate that the body with practice gradually re-establishes the power of oxidising fat. The same behaviour has been noticed in diabetes when a rigid diabetic diet is given; the acidosis at first increases and subsequently diminishes. However, the fall in alveolar CO_2 in a normal individual is really not very large. It is at the most slightly over 1 per cent.

In diabetes you may not have any acidosis at all in the milder cases, but I am not concerned with this type of case in the present lecture.

In a number of observations on diabetics, where the urine showed evidence of acidosis, I have found that they can readily be divided into two clinical groups by means of measuring the alveolar CO_2.

In the first group the acidosis is mild; for there is practically no alteration in the alveolar CO_2, or at most the alveolar CO_2 falls by about 1 per cent. when a rigid diet is first started, and subsequently rises to the normal level. Of course this acidosis is quite independent of the amount of sugar that is being passed.

CASE OF SEVERE DIABETES—COMA.

Date. Nov.	Alv. Co_2 per cent.	Sugar gms.	Ammonia Nitrogen.	Acidity Urine.	Ammonia Index.	Aceto-acetic Acid gms. reckoned as Acetone.	B.O.
23	3·2	266	3·42	1,740	15·5	7·97	E.
24	3·1	353	3·55	1,640	16·0	7·03	
25		378	3·13	1,170	14·0	9·32	
26		157	Loss of urine.				
27	4·2 (3.30 p.m.)	397	2·76	1,090	13 0	7·66	3.
28	3·9 (8.30 a.m.)						2.
29		259	3·26	1,255	17·0	6·9	
30	2·7 (9.0 a.m.)	165	3·00		16·4	4·6	
Dec. 1	1·4 (11.0 a.m.)	Coma stated to be imminent on previous night.					2.

In the second group the acidosis is severe and the alveolar CO_2 is definitely lower than normal, and the prognosis with regard to the onset of coma is relatively bad. The greatest care must be taken in the treatment of these cases to avert coma. Here is a table that will illustrate the degree of acidosis often met with.

The patient was a woman about 30 years old, who had been suffering from diabetes for about a year. On entry into hospital she was obviously one of the severest types of case, and you see that in spite of everything we could do she died in coma not very long after admission. The carbohydrate in her diet was not restricted in any way.

The chief points in the case can readily be seen on comparing the numbers with the corresponding ones for a healthy individual during starvation in the previous tables.

To begin with, the alveolar air was very much lower; it was never much over 4 per cent., and at the beginning of coma the very low value of 1·4 per cent. was obtained. The ammonia nitrogen was over 3 grms.; compare this with 1·0 grm. obtained on the third day of a protein and fat diet. The acidity of the urine was about trebled, and the aceto-acetic acid was six or seven times as much.

The sixth column gives the figures for the ammonia index; by this is meant the ratio of the ammonia nitrogen to the total nitrogen. Under normal circumstances this ratio is about 4 per cent., but in severe acidosis it is usually over 10 per cent. and may rise to 20 or 30 per cent. In the case under consideration the values were about 15 per cent.

There is another point that this table brings out, viz., the effect of constipation on acidosis. It is a well known clinical fact that constipation is apt to cause the onset of coma. Dr. Graham has informed me that in a case he observed during some months, the acidosis as indicated by alveolar CO_2 determinations increased when the patient became constipated and vice-versa. This point is well shown in the table. The patient was very constipated, and it was with difficulty that the bowels were kept open. However, on November 27th and 28th the bowels were opened five times. You see that on this date the alveolar CO_2 rose from 3 per cent. on admission to 4 per cent. Subsequently the alveolar CO_2 again diminished and the patient passed into coma.

In the next lecture I shall consider briefly the clinical examination of a case of acidosis, and then discuss the treatment and the theory on which treatment is founded.

Correspondence.

To the Editor of Guy's Hospital Gazette.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—Ed., G.H.G.]

Dear Sir,—I should like to bring to your notice the extremely good services rendered by J. Hanson, who was employed at Guy's for about ten years prior to his joining the army at the beginning of the war.

On the 1st August our billets were heavily shelled, one shell striking a house close by, which was full of women and children. One child was killed and two women and six children were wounded. My men got them out of this house under some form of cover, and Gunner Hanson at once started to attend to the wounded. Our medical officer was on the spot, but devoted himself entirely to the two most serious cases, and Hanson dealt with all the others without instructions, and was highly praised by the medical officer for the skill and rapidity with which he worked under most trying conditions.

I have submitted Gunner Hanson's name for mention in dispatches, but owing to the very large number of men whose conduct calls for such an honour, by far the greater number are, of necessity, cut out, and so I am writing to let you know, as I am sure it must be a matter of interest to hear of good work being done by one of your late staff.

It is not everybody who can keep his head under shell fire, and apply the knowledge that he has acquired in civil life.—Yours faithfully,

112th Heavy Battery, JOHN C. HANNA,
3rd Heavy Brigade, R.G.A. Major.
B.E.F. Comdg. 112th Heavy Bat.

[Gunner Hanson was employed in the Laundry Department, and we would like to offer our hearty congratulations to him.—Ed.]

Change of Address.

Lieutenant T. A. Townsend, 2/1 London Field Artillery, Union Workhouse, Ipswich.

Lieutenant Gerald E. Lockyer, R.A.M.C., Delhi Barracks, Tidworth.

Surgeon-Dentist J. R. Wallis, Delhi Barracks, Tidworth.

Lieutenant M. E. Ball, R.A.M.C., Delhi Barracks, Tidworth.

Captain R. E. G. Phillips, R.A.M.C., Reserve of Officers, S.M.O. Recruiting, Stratford Area, London District.

Additional List of Guy's Men on Active Service.

MILITARY.

ALLEN, Captain T. S., R.A.M.C.	No. 12 General Hospital, B.E.F.
ANDREWS, Lieutenant G. Genge, R.A.M.C.	M.O., 32nd Reserve, —— B.E.F.
BLAKE, Captain G. A., R.A.M.C.	No. 6 Combined Field Ambulance, Malahand Moveable Column.
BOOKLESS, Lieutenant J. S., R.A.M.C.	No. 24 General Hospital, B.E.F.
CLARKE, Captain H. M., R.A.M.C.	H.M.H.S. *Aquitania*, c/o G.P.O.
HANCOCK, Lieutenant A. C., R.A.M.C.	27th Field Ambulance, 9th Division, B.E.F.
HARDY, Lieutenant G. Frank, R.A.M.C.	23rd Brigade, R.G.A., B.E.F.
HAYCRAFT, Lieutenant G., R.A.M.C....	3rd Field Ambulance, 46th Division, B.E.F.
LIEBSON, Captain S. A., S.A.M.C.	M.O., 3rd Infantry Regiment, 1st S.A. Overseas Contingent.
LUCAS, Major T. C., R.A.M.C.	Attached ? Hospital, Alexandria.
MATSON, Lieutenant R. C., R.A.M.C....	71st Field Ambulance, B.E.F.
MULLALLY, Captain G. T., R.A.M.C....	No. 8 Casualty Clearing Station, B.E.F.
REINHOLD, Captain C. H., I.M.S.	Lahore Division.
ROBERTS, Lieutenant C. S. L., R.A.M.C.	27th Field Ambulance, 9th Division, B.E.F.
STRANGE, Captain E. W., R.A.M.C.	3rd Field Ambulance, 46th Division, B.E.F.
SYMS, Lieutenant J. L., R.A.M.C.(T.)	88th Field Ambulance, 29th Division, B.M.E.F.
TAYLOR, Lieutenant E. S., R.A.M.C.(T.)	2nd London Casualty Clearing Station, B.E.F.
WALLIS, Lieutenant W. E., R.A.M.C.	No. 18 General Hospital, A.P.O., S. 18, B.E.F.
WHITWORTH, Captain H. P., R.A.M.C.(S.R.) ...	27th Field Ambulance, 9th Division, B.E.F.
WRIGHT, Captain C. S. E., R.A.M.C.	No. 7 Stationary Hospital, B.E.F.

NAVAL.

BAILEY, Surgeon E. R.	H.M.S. *Halcyon*, c/o G.P.O.
BEADNELL, Fleet-Surgeon C. M.	H.M.S. *Shannon*, c/o G.P.O.
BIDWELL, Fleet-Surgeon L.	H.M.S. *Marmora*, c/o G.P.O.
BROWNE, Fleet-Surgeon R. H. J.	H.M.S. *Challenger*, c/o G.P.O.
BUCKERIDGE, Staff-Surgeon G. L.	H.M.S. *Halcyon*, c/o G.P.O.
DANBY, Temporary Surgeon A. B.	Monitor No. XVII., c/o G.P.O.
DENNY, Staff-Surgeon H. R. H.	H.M.S. *Royalist*, c/o G.P.O.
DEPREE, Temporary Surgeon H. T.	H.M.S. *Vivid*, c/o G.P.O.
DUNCAN, Fleet-Surgeon G. E.	H.M.S. *Europa*, c/o G.P.O.
ELLIOTT, Temporary Surgeon E. L.	M.F.A. *Somali*, c/o G.P.O.
ENDEAN, Surgeon F. C.	H.M.S. *Vivid*, c/o G.P.O.
GALLOWAY, Temporary Surgeon W. D.	H.M.S. *Cornwallis*, c/o G.P.O.
GOULD, Temporary Surgeon C. H.	H.M.S. *Dartmouth*, c/o G.P.O.
GOBLE, Surgeon F. P.	C/o Admiralty.
HENRY, Surgeon A. W.	H.M.S. *President*, c/o G.P.O.
HOLE, Surgeon H. K.	H.M.S. *Thames*, c/o G.P.O.
IREDELL, Staff-Surgeon A. W.	H.M.S. *Proserpine*, c/o G.P.O.
IRVINE, Surgeon L. C. Dundas, R.N.V.R.	H.M.S. *Cornwallis*, c/o G.P.O.
KING, Temporary Surgeon G. W.	H.M.S. *Dublin*, c/o G.P.O.
JONES, Fleet-Surgeon M. P.	H.M.S. *Exmouth*, c/o G.P.O.
MAY, Fleet-Surgeon P. N.	H.M.S. *Empress of India*, c/o G.P.O.
MILLETT, Lieutenant H., R.M.	Royal Naval Division, B.M.E.F.
MINETT, Surgeon P. F.	Royal Naval Hospital, Chatham.
PERKINS, Temporary Surgeon H.	H.M.S. *Thistle*, c/o G.P.O.
RANKINE, Surgeon R. A.	M.F.A. *Somali*, c/o G.P.O.
ROBINSON, Staff-Surgeon F. C.	C/o Admiralty.
SCHLESINGER, Temporary Surgeon E. G.	R.N. Division, *Howe* Battalion.
SMITH, Staff-Surgeon F. M. V.	H.M.S. *Changuinole*, c/o G.P.O.
SPRAGUE, Surgeon C. G.	C/o Admiralty.
SYMS, Surgeon G. F.	H.M.S. *President*, c/o G.P.O.
THOMAS, Staff-Surgeon A. R.	H.M.S. *Talbot*, c/o G.P.O.
TONGUE, Temporary Surgeon E. J.	H.M.S. *Ganges*, for Shotley, c/o G.P.O.
TUCK, Fleet-Surgeon E. S.	H.M.S. *Natal*, c/o G.P.O.
VICARY, Temporary Surgeon V. P.	H.M.S. *Victory*, c/o G.P.O.
WERNET, Staff-Surgeon A. J.	H.M.S. *Canopus*, c/o G.P.O.

PROBATIONARY SURGEONS.

ALLEN, Surgeon-Probationer W. J. McBain... ...	H.M.S. *Mallock*, c/o G.P.O.
TURNER, Surgeon-Probationer W. A., R.N.V.R. ...	H.M.S. *Ostrich*, c/o G.P.O.

Lectures* for Sessions 1915—1916.

WINTER SESSION. OCTOBER—MARCH.

†	LECTURERS.		DAYS.
Anatomy (1st & 2nd)	Mr. Fagge and Mr. Rowlands	4	— Tu — Th — —
Microscopical Pathology (3rd) ...	Dr. Laidlaw and Dr. Eyre	2.30	— — W Th(10) — —
Pathological Classes (3rd & 4th)	Dr. Laidlaw and Dr. Goodhart ...	—	— W(11.30) Th(9.15) Sat(11)
Bacteriology (Jan. to Mar.) (4th)	Dr. Eyre and Dr. Lucey	4	— Tu — — — —
Practical Obstetrics (3rd & 4th)	Mr. Pochin (Oct. and Jan.)	12	M — — — — —
Chemical Physiology (Jan.) (2nd)	Dr. Pembrey, Mr. Ryffel & Mr. Marshall	11	— — — — Fri Sat
Chemistry (1st and pre. sci.) ...	Professor Lowry	9.30	— Tu — Th — —
Practical Chemistry	Professor Lowry, Mr. Merriman and Mr. Rogerson	10.30	— Tu — Th — —
Advanced Practical Physiology (3rd)	Dr. Pembrey, Mr. Ryffel, and Mr. Marshall	11	M — W — — —
Practical Medicine (3rd) ...	Dr. Mutch, Mr. Barber and Mr. Heaton	—	———
Experimental Physics (pre. sci.)	Dr. Fison	3	M Tu — — — —
Chemical Physics (1st)	Dr. Fison and Mr. Abram	11	M — — — Fri (2) —
Practical Surgery (3rd)	Mr. Todd, Mr. Mullally, Mr. Schlesinger and Mr. Ozanne	12.30	— Tu — — Fri —
Physiology (2nd)	Dr. Pembrey (Oct.-Dec.)	10	M — W — — Sat
Clinical Medicine (3rd & 4th) ...	The Physicians	1.30	— — W — — —
Surgery (3rd)	Sir Arbuthnot Lane, Mr. Dunn, Sir Alfred Fripp and Mr. Steward	5	M — — — Fri —
Clinical Surgery (3rd & 4th) ...	The Surgeons	1.30	— — W — — —
Elementary Biology (1st) ...	Mr. Evans and Mr. Reed	9.30	— — W Th(2) Fri —
Morbid Anatomy (3rd & 4th) ...	Dr. French, Dr. Cameron and Dr. Hunt	2	M Tu W Th Fri Sat(12)
Medicine (3rd)	Dr. Hale White, Dr. Shaw, Dr. Fawcett and Dr. Beddard	4	— — W (3) — Fri —
Ophthalmic Surgery (Jan.) (4th)	Mr. Eason	4.15	— — W — — —
Public Health (Jan.) (4th) ...	Dr. King Brown	4	M — — — Fri —
Anæsthetics	Mr. Rowell (Dec.)	—	———
Dental Surgery and Pathology...	Mr. Wynne Rouw	4	— — — Th — —
Metallurgy	Professor Lowry	4	M — — — — —
Practical Dental Metallurgy ...	Mr. Pearce (Jan.)...	2.30	— Tu — — — —
Dental Anatomy & Physiology...	Mr. Hopson	4.15	— — W — — —
Dental Mechanics	Mr. Lewin Payne (Oct.–Dec.)	4	— Tu — — — —
Practical Dental Mechanics ...	Mr. Pillin (Jan.)	2.30	— — — — Fri —
Pathology	Dr. Laidlaw	12.15	— — — Th Fri —

SUMMER SESSION. MAY—JULY.

†	LECTURERS.		DAYS.
Medical Jurisprudence (3rd & 4th)	Mr. Ryffel	4	M — — — Fri —
Midwifery (3rd)	Mr. Bellingham Smith and Mr. Chapple	9	— Tu W Th — —
Diseases of Women	Mr. Bellingham Smith and Mr. Chapple	9	— — — — Fri —
Mental Diseases (3rd)	Dr. Craig	9.30	M — — — — —
Bacteriology (April to June) (4th)	Dr. Eyre and Dr. Lucey	4	— — W Th — —
Practical Obstetrics (3rd) ...	Mr. Pochin	12	M — — — — —
Biology and Botany (pre. sci.) ...	Mr. Evans and Mr. Reed	2	— — W — Fri —
Physiology (2nd)	Dr. Pembrey	9.30	M — W — — Sat
Histology (1st)	Dr. Pembrey, Mr. Ryffel, and Mr. Marshall	10.30	M — W — — Sat
Practical Surgery (3rd)	Mr. Todd, Mr. Mullally, Mr. Schlesinger and Mr. Ozanne	12.30	— Tu — — Fri —
Practical Medicine (3rd) ...	Dr. Mutch, Mr. Barber and Mr. Heaton	12	— — — Th — —
Experimental Physics (pre. sci.)	Dr. Fison and Mr. Abram	3	M Tu — — — —
Clinical Medicine (3rd & 4th) ...	The Assistant Physicians	1.30	— — W — — —
Clinical Surgery (3rd & 4th) ...	The Assistant Surgeons	1.30	— — W — — —
Morbid Anatomy (3rd & 4th) ...	Dr. French, Dr. Cameron and Dr. Hunt	2	M Tu W Th Fri Sat(12)
Therapeutics	Dr. Beddard	4	— — — Th — —
Anæsthetics	Mr. Rowell (June)	—	———
Operative Dental Surgery ...	Mr. Parfitt	2	— Tu — — — —
Chemistry	Professor Lowry	9.30	— Tu — Th — —
Practical Chemistry	Mr. Merriman and Mr. Rogerson ...	10.30	— Tu — Th —Sat(10)
Exp. Pathology (Gordon Lectures)	Dr. Laidlaw	12.30	— — — — Fri —
Pharmacology	Dr. A. J. Clark	—	———

* No effort has been made to include the many demonstrations or practical work.

† The numbers in this column refer to the years in which this course should be attended.

Members of the Staff who are on Active Service, and their Substitutes.

NAME.	APPOINTMENT.	SUBSTITUTE.
Dr. A. J. Clark	Lecturer on Pharmacology ...	Dr. Laidlaw.
T. B. Heaton	Medical Registrar	Other Registrars.
G. T. Mullally, E. G. Schlesinger, R. C. Ozanne	Surgical Registrars, Demonstrators of Anatomy, and Anæsthetists	F. D. Saner and A. M. Zamora (as Anæsthetists and Demonstrators of Anatomy).
G. Marshall	Demonstrator of Physiology ...	(No one appointed, duties shared between Dr. Pembrey, Dr. Poulton, and Mr. Ryffel).
W. S. Stranack, G. B. Pritchard, and L. Price Harris	Demonstrators of Practical Dentistry	Other Demonstrators.
Mr. Layton	Surgeon-in-Charge of Throat and Ear Department	Mr. Mollison.
Mr. Turner	Assistant Surgeon	Wards, Mr. Trethowan; O.-P.'s Mr. Gardiner: Revision Classes, Mr. Todd: Operative Surgery, Mr. Bromley.
Mr. Davies-Colley	Assistant Surgeon	O.-P.'s and Lectures, Mr. Saner and Mr. Bromley.
Dr. Hunt	Assistant Physician	Dr. Poulton.

The Sciences.

Anatomy and the Dissecting Room.

The primary object of dissecting is to learn anatomy. By seeing the structures lying in their proper relations one to another a mental picture is obtained which cannot be had by reading or looking at pictures; by cleaning these structures and tracing them from above downwards their course is impressed on the mind; and by removing each muscle from its attachment those facts are learnt which have been taken for granted when first reading the bone.

In addition, dissecting trains the fingers and develops the sense of touch, and that delicate muscle sense which is so necessary to aid the eye in carrying out a delicate manipulation.

The basis of anatomical knowledge is a thorough acquaintance with the bones. These can only be learnt by handling the bone and making out each point on it as the description in the book is being read. Hence it is absolutely essential to buy a half skeleton and a disarticulated skull. (These may be had from Hancock, the dissecting-room porter, who will also supply apron and sleeves—price 2s. 6d.—and cases of instruments).

The man who sits in an easy chair with an open Gray upon his knees and no bones by his side is simply wasting his time.

BOOKS AND INSTRUMENTS.

The student must have two books of anatomy, the one to read it systematically by starting with each muscle, nerve, or other structure, the other to read it topographically as each structure is exposed in the course of dissection.

The book for the latter is Cunningham's Practical Anatomy (2 vols., 10s. 6d. each); it should be taken into the room and read before, during, and after each day's work.

The best books for the former are Gray's or Cunningham's Anatomy. Those reading for higher examinations might also get Quain's Anatomy, of which the eleventh edition is now appearing in parts. These will also need at some period a book on Embryology. The best book on this subject for students is Keith's as it is written from a surgical point of view.

The following instruments are necessary:—Three scalpels, two pairs of *dissecting* forceps, and two sets of "hooks." No other instruments are necessary, and the small forceps used in the biological department are worse than useless.

HOW TO BEGIN WORK.

The following rules will help:—

1. Bring up an old coat, and procure an apron and sleeves. These keep you clean. Men are sometimes seen dissecting in their everyday coat, or in their shirt-sleeves without rolling them up. The cuffs and arms then get sodden in fat and body fluid, which substances are transferred in the evening to the dinner cloths of the student's parents or landlady. Such dirty habits need no comment.

2. Deposit 5s. at the Medical School Office and procure the key of a locker in which to put these and other requisites for dissection.

3. Attend at 12 noon on Friday, October 1st, the introductory demonstration given by the Senior Anatomy

Demonstrator. You will there be given a "Red Book" containing the rules of the dissecting-room, and will be told in greater detail than is possible here, the ways of the room and the work to be done.

4. In the afternoon of October 1st look for your name on one of the lists, and find out what part has been allotted you. Then find out the times of the bone and other classes which correspond to this part. They are held by Mr. Mullally, Mr. Todd, Mr. Schlesinger and Mr. Ozanne.

5. Either that afternoon or early next morning begin dissecting, and remember

(i.) Not to be in a hurry.

(ii.) To read carefully in your book (Cunningham) the pages describing the surface markings of the part, and the lines of incisions that must be made.

(iii.) To turn back *the skin only*, leaving the fat upon the body.

(iv.) To remove carefully this fat, leaving intact the white layers of "deep fascia" which cover the muscles.

(v.) To clean the surface of the muscles. Cut with the grain or muscle fibre, and clean it *right up to its attachment to the bone.*

(vi.) Always read ahead of your dissection, either in the pickle-room, or wax-model museum.

PHYSIOLOGY.

Physiology, which forms the basis upon which scientific medicine and surgery rest, will require the most earnest attention on the part of the student during the short space of two years which he can devote to it, and he will find that his understanding of the medical, surgical and pathological problems with which he will meet later on varies directly with the thoroughness of his physiological ground work. While attendance at physiology lectures and the reading of some elementary work on the subject, such as Huxley's *Elementary Lessons in Physiology*, or the smaller works by B. Moore and by Foster and Shore, during the first year is undoubtedly useful, yet for most men the practical study of Physiology begins in the first summer session. During this session he attends the classes in Practical Histology which are held three times a week, and for which he will need a microscope, certain mounting materials, and Schäfer's *Essentials of Histology*, which should be carefully studied.

During the first summer session and the first half of the second winter session the student should attend the lectures on Physiology (for times, *vide* table, p. 377), and also the tutorial classes which are held by the demonstrators. During this time he should read the subject in some text-book such as Starling's *Principles of Human Physiology*, Halliburton's *Handbook of Physiology*, Stewart's *Manual of Physiology*, or Howell's *Text-book of Physiology*. While attending the practical classes held during the winter the student is advised to read *Practical Physiology* (published by Arnold).

Candidates for the M.B. of London or other Universities must in addition attend the class in advanced practical physiology held twice a week during the second winter session, and this class should also be attended by men working for the first F.R.C.S. examination.

Those desirous of obtaining distinction in the second M.B. examination should supplement the course of reading indicated above with original papers in the *Journal of Physiology*, with parts of Schäfer's *Text-book of Physiology*, *Recent Advances in Physiology and Bio-chemistry*, edited by L. Hill; *Further Advances in Physiology*, edited by L. Hill; and Leathes' *Problems in Animal Metabolism*. Revision classes are held by the demonstrators during the two months preceding the first F.R.C.S. and the M.B. examinations and should be attended by all candidates.

CHEMISTRY AND PHYSICS.

The student is often tempted to regard the study of Chemistry and Physics as one of very little use when once his preliminary examination is passed; but he will find in his study of the sciences of Physiology, Pharmacology and Pathology that a proper understanding of Chemistry and Physics is invaluable and essential. That this is so, is now fully recognised in the curriculum of the London University which should be carefully studied by every London student.

The matriculated student will, in his first year, study Inorganic Chemistry, Physics, and General Biology, and at the end of this period, provided he has worked diligently in the laboratories, and attended the lectures and revision classes regularly, should have no difficulty in passing the First Examination for Medical Degrees. In his second year he will study Organic and Applied Chemistry, together with Anatomy and Physiology, and at the end of the second winter, provided, as before, that he has worked steadily from the commencement, should have little difficulty in passing the First Part of the Second Examination for Medical Degrees. Anatomy, Physiology, and Pharmacology are then taken as the Second Part of this Examination, at the close of the third winter, prior to commencing clinical work in the wards.

From the Conjoint and the Dental student only six months' work is required. but those entering without previous knowledge of Chemistry and Physics will find that time hardly sufficient, and are usually advised to take the full "year" of three terms, or nine months.

The importance of practical work cannot be too greatly emphasized, and lectures and books can but supplement work done in the laboratory. Guy's men have no excuse for neglecting laboratory work. The Chemical Laboratory, for example, is open from 9 a.m. to 5 p.m. on Mondays, Tuesdays and Wednesdays, and from 9 a.m. to 6.30 p.m. on Thursdays and Fridays, and students are strongly urged to form early the habit of spending their spare hours, apart from those officially allotted, in one or other of the laboratories. Reading

should be left for the evening. After a day in the laboratory, reading a good text-book will be found to give ample scope for thought, and rarely, indeed, be practical experience that is so destructive of thought, and such reading is very properly stigmatised as "cram." "Cramming," or the memorising of words and phrases, without a knowledge of the corresponding realities, is one of the worst intellectual habits a student can acquire, and in the long run invariably leads to failure.

For the coming term, Chemistry Lectures start on Tuesday, October 5th, at 9.30 a.m. (Chemical Theatre, entrance opposite Laboratory, third floor); but before this, students should go to the Chemical Laboratory on Friday, October 1st, at 10 a.m., to receive their locker keys and apparatus and commence practical work. Practical Organic and Applied Chemistry starts on Friday, October 1st, at 2 p.m., and the Lectures on Saturday, October 2nd, at 10 a.m. Physics Lectures commence on Monday, October 4th, at 3 p.m. (Class Room IV., second floor).

PRACTICAL PHARMACY, MATERIA MEDICA, AND DISPENSING.

One of the many important things all medical students must know is how to write a prescription; it may even be necessary for the majority, when qualified, to know how to dispense the same, so that the student will do well not to neglect acquiring as much knowledge of this subject as he can.

The student is taught practically the methods of prescribing, he practises writing prescriptions for combinations of drugs with due regard to incompatibility, and he is taught how to dispense the prescriptions he has himself written.

The course covers the syllabus of the Practical Pharmacy of the Conjoint, the Intermediate M.B. Lond., and the Third M.B. Cantab.

During the year there may be three courses of three months each, should a sufficient number of students require instruction, which is given in the practical pharmacy class at the Dispensary by Mr. Finnemore, B.Sc. Lond., F.I.C., the Hospital Pharmacist.

MEDICAL WARDS.

To each medical ward clerk is allotted a certain number of beds, and he is expected to examine, and write full reports on all patients who are admitted into these. Occasionally it so happens that a patient is too ill to be examined except by the house-physician and physician, or that a case dies or is discharged before the ward clerk has had an opportunity of seeing it. Under these circumstances he should obtain the history, and an account of the symptoms, physical signs, and progress of the case from the house-physician, and should base his report on these data. It cannot be too strongly insisted that a report, however brief, must be written on every case, and it is of the greatest importance that the diagnosis and remarks made by the Physician should be entered at once into the report. Moreover, any errors detected by the Physician or Registrar in the original report should be immediately corrected. In the event of a patient dying the ward clerk must obtain the abstract of the post-mortem findings, and carefully enter it up, and it need hardly be said that all clerks should make every effort to see the post-mortem examination on any case they may have seen during life.

The medical wards are open to clerks from 10 till 12.30 in the morning, and from 1.30 till 5.30 or 6 in the evening. The Registrars begin their rounds at 10.30, and by that time a clerk should at least have full notes of the history of any new patient who may have been admitted into one of his beds; and he should have a full report in readiness for the Physician in the afternoon. Ward clerks should realise that they are expected to know the details not only of their own cases, but of every patient under their Physician. It is no excuse to plead ignorance because "this is not my case." If only a clerk will take the trouble to make himself conversant with each case in this way, he will find at the end of his six months that an enormous amount of clinical material has passed through his hands, and he will probably have acquired enough knowledge of medicine to enable him to pass the Conjoint Final with but little additional reading. But so many men waste their time through sheer laziness in the medical wards, never realising that they are throwing away experience which would prove invaluable to them later on.

An hour spent in the wards after tea three or four times a week will give opportunities, not only for going over cases and writing up reports, but also for seeing the house-physician tap chests and abdomens, etc. The treatment, too, which each case is receiving, may well be studied at this time.

As regards reading, the best method is to study the text-book account of each disease as one comes across it in the wards or in discussion, and afterwards to compare, if possible, the text-book description with the symptoms and signs presented by the patients. At the same time, the most important medical journals should be read regularly, for by this means only can the student keep himself in touch with modern work.

Books that may be recommended are the following:—The well-known text books by Taylor and Osler, "Medical Diagnosis," by Latham and Torrens (a most valuable work), and "Auscultation and Percussion," by Gee. For second three months ward clerks Dieulafoy's "Text-book of Medicine," the most important monographs in Allbutt's "System of Medicine," and Campbell Thomson's "Diseases of the Nervous System," will prove valuable and interesting reading. For laboratory work Hutchinson and Rainey's "Clinical Methods," or Dr. French's book may be useful for reference.

PATHOLOGY.

As soon as a student has passed his Second Conjoint or M.B. examination, he should begin his study of pathology. Without a sound knowledge of this science it will be impossible for him to obtain any real knowledge of medicine or surgery, and he can, therefore, never be too emphatically urged to attend the autopsies on everyone of his cases, and to spend as much time as possible in the post-mortem room. Autopsies are conducted every day of the week at 2 p.m. (Saturdays at noon), by Dr. French, Dr. Cameron and Dr. Hunt. The microscopical examination of material removed by operation, is often the only means of arriving at a definite diagnosis, and it is therefore equally important that the student should obtain an adequate knowledge of microscopical appearances in disease.

Classes on microscopical pathology are held by Dr. Laidlaw and Dr. Eyre on Wednesday afternoons and Thursday mornings throughout the year. Bacteriology being taken in October to December and April to June, and morbid histology from January to March and July to September. Further the student should attend Dr. Hunt's classes on medical pathology, and Mr. Davies-Colley's on surgical pathology which are held three times a week.

In order to learn something of the principles which underlie pathology, the student should attend the lectures on general pathology. In May and October there are also informal classes adapted for the requirements of candidates for the first part of the Third M.B. Cantab., and the final M.B. of Oxford and London Universities.

The best elementary manuals are Green's "Pathology" and Adami and Macrae's "Text-book of Pathology"; Hewlett's "Pathology, General and Special" is good but hardly full enough. For general pathology read "General Pathology," edited by Pembrey and Ritchie, and for morbid histology Grünbaum's "Essentials of Morbid Histology," or Woodhead's "Practical Pathology," of which the illustrations are very good. Many of the articles in Allbutt and Rolleston's "System of Medicine" should be consulted. For bacteriology Muir and Ritchie's "Manual of Bacteriology" is recommended.

BACTERIOLOGY.

Every Guy's man devotes at least three months to the practical study of Bacteriology. This compulsory course comes under the heading of Microscopical Pathology, and is held every Wednesday afternoon and Thursday morning from October to December, and again from April to June.

Bacteriology, although one of the youngest of the auxiliary sciences, has already made a most profound impression upon the theory and practice of both medicine and surgery, and by providing appropriate and specific treatment for bacterial infections has created the demand for exact as well as accurate diagnosis. Consequently, particular attention is devoted in this class to the technique of the various investigations undertaken in connection with the ward work. The student himself stains sputum, pus and morbid exudates by various methods to demonstrate the associated bacteria. He estimates the amount of specific agglutinins or opsonins contained in the serum of patients under treatment in the wards. In addition, he is instructed in the practical work of media-making, culture and staining methods, and is encouraged to repeat for himself during the intervals between successive classes any observations and experiments previously carried out, in order that he may be adequately prepared to take advantage of the advanced classes and lectures which are available during the fourth and fifth years of study, and to equip him for the performance in general practice of those more obvious methods of bacteriological diagnosis, which the past generation of medical men are compelled to entrust to the pathological experts of their own or other hospitals, or, as so often happens, to the various commercial houses which make a speciality of clinical research and diagnosis. Demonstrations are also given upon the life-history of the various organisms pathogenic to the human race, and the changes such organisms undergo or produce when they gain entrance to the human tissues.

In order that the student may make the fullest possible use of his opportunities of correlating the clinical symptoms resulting from the infection of the patient's tissues by various pathogenic organisms, the class in bacteriology should be taken out as early as possible during the period of clinical study, and the work has so been planned that the whole of the six months devoted to microscopical pathology may run coincidently with the appointment of medical or surgical clinical clerk: and it should be emphasised that the clerk's absence from the wards during the hours the class is being held is not only sanctioned, but, indeed, is expected by his chiefs.

During February and March of each year a course of lectures is given dealing even more specially and technically with the applications of bacteriology to practical diagnosis and treatment, and in these the various remedial agents (serums and vaccines) which have been elaborated in the bacteriological laboratory for the treatment of disease are fully discussed, together with the facts and theories relating to natural and acquired immunity upon which bacteriological therapy is based.

THE SURGICAL WARDS.

In the surgical wards there is a division of labour, and corresponding to this division, the appointments fall into two classes—clerking and dressing. The student's first introduction to clinical work is as clerk in the surgical wards, and it is not unlikely that he may, on his first entry, be a trifle discouraged. The reasons for this are obvious. Entirely ignorant of surgery and even of the terms in common use, he is at once required to write

full accounts of the cases admitted to the wards. He will find, however, that, with the assistance available at his disposal, his difficulties will be found to be anything but insurmountable.

The most important point for a clerk to remember is that in after years cases and not book work will form his mainstay in practice, and that he cannot too soon get the clinical entity and results of treatment into his memory.

Let him bear in mind that to him is given by the hospital the task of keeping its records. These are bound and kept, and by his work thus perpetually in evidence, a man is judged. Bad reports are a lasting disgrace; good reports a lasting honour. There is no better way of impressing the facts of a case on one's mind than is gained by the construction of a correctly detailed report, which, moreover, will be of value if the case has to be referred to at a future date. The importance of good careful work by the clerks cannot be over-estimated. In the nature of things it cannot be perfect, but it must be as perfect as he can make it. By his first work in the wards he will be judged, and he will find that it is very hard to live down a bad clerkship. At the same time that he bears in mind the difficulties and responsibilities of his post, he should remember that he is a junior, and that any assistance he can lend his seniors should be offered ungrudgingly, and in return for this he will undoubtedly meet with that consolation and help in his work which is so necessary.

It is essential that either the clerk should live within walking-home distance of the hospital, or else get a room for the take-in week. All really good casualty work is done at night, and the periods for seeing the actual application of plaster splints, the reduction of fractures, the immediate treatment of all kinds of urgent cases, is all too short as it is. A man who is appointed as clerk to an assistant surgeon should attach himself, during take-in week, to the corresponding full surgeon's firm, and work with its dressers and clerks in the surgery and theatres.

As soon as he is appointed, the Surgical Ward Clerk should obtain from the Medical School office a copy of the "Notes on Surgical Case-taking," and peruse it most carefully. It contains a wealth of information upon the duties of the appointment, and upon the kind of information which has to be elicited from the patients. A day or two before he actually has to undertake his new work, the clerk will meet the surgical registrar, who will instruct him further as to his precise duties, the mode of taking and indexing reports, the mode of dealing with pathological and bacteriological reports, and all the other duties appertaining to his post. He should then learn from his predecessor what he can about the cases he is to take charge of, so that the work may be continued as nearly as possible without a break. There is an entire change of clerks every three months, but in the way indicated above, the break in the work may be obviated to some extent. He should learn quickly to take accurate pulse and respiration rates, and test urine, for without any exception the temperature, pulse and respiration rates, and condition of the urine must be included in the notes of every case on admission. The surgical registrar sees every new case with the clerk on the morning after admission, when he expects a history of every case to be ready. This, if vague, is useless. All symptoms should be set down in exact order, with the dates of their appearance.

The surgeon's diagnosis, and the reasons for it, should always be recorded, and the exact condition found at operation, if such be performed. It must be remembered that the condition of every part investigated must be noted down, and not only that of the particular viscus affected. In many cases, patients return after some while, and it is very desirable to have a detailed record of every viscus examined. Negative points, too, should be noted, as well as positive findings. Thus in a laparotomy it is quite as important to state that the stomach and duodenal seemed normal, and that no gall-stones were present, as to say that a normal-looking appendix was excised.

The exactness in detail is of the highest importance, and is a measure of the care with which the clerk has done his work. He should have a note-book, and should put down in it everything about the case that he can obtain from the surgeon, house-surgeon, clinical assistant, and dresser. This should be copied into the report as soon as possible. We would impress upon each clerk the value of seeing everything done by the dressers or house-surgeons —the operations, putting up fractures, especially when done at night in take-in week, and this should apply to manipulations on every case under the surgeon, and not only to the cases which the individual clerk has to report—as much may be learnt in this way which otherwise can only later be gathered with much greater effort.

He should also attend the practical surgery classes of the surgical registrar, who gives four courses a year, each beginning on the appointment of the new surgical ward clerks, and especially designed for their instruction in all matters relating to that appointment, and also the course of practical pathology which is then in progress.

Lists of the duties appertaining to each appointment are supplied to the students, and these are to be carefully followed out. The hospital not only expects this, but insists on it. We have laid stress so far on the appointment of surgical ward clerk, as it is the first post that the student holds, and because he is so often quite unaware of the objects of the appointment.

The surgical wards are visited every day by the surgeons and assistant surgeons at 1.45. Notice of operations, which daily take place except for emergencies, is posted overnight in the colonnade by the House-Surgeon for the week. The surgeons are assisted atthe operations by the dressers, and the particular clerk to the case should remain close by throughout the whole operation.

Although we believe there is no rule which prevents freshmen attending operations and clinical demonstrations, we would point out that such a course of action is useless to them, and is not encouraged by the authorities.

DAYS AND HOURS OF ATTENDANCE ON HOSPITAL PRACTICE.

Accidents and urgent cases of all kinds are admitted by the Maze Pond entrance at any time of the day or night.

THE WARDS.

Medical Wards.—Dr. Hale White (2), Mondays, Tuesdays and Thursdays. Dr. Shaw (2), Mondays, Tuesdays (10.30), Thursdays (10.30) and Fridays. Dr. Fawcett (2), Mondays, Tuesdays, Thursdays and Fridays. Dr. Beddard (2), Mondays, Tuesdays and Fridays.

Surgical Wards.—Sir W. Arbuthnot Lane (2), Mondays, Tuesdays, Wednesdays, Thursdays and Fridays. Mr. Dunn (1.30), Mondays, Tuesdays, Wednesdays, Thursdays and Fridays. Sir Alfred Fripp (1.30), Tuesdays and Fridays. Mr. Steward (1.30), Mondays, Tuesdays, Thursdays and Fridays. Operations (1.30) daily.

Obstetric Ward.—Mr. Bellingham Smith (2), Tuesdays and Fridays. Mr. Chapple (2), Mondays, Wednesdays and Thursdays.

Ophthalmic.—Mr. Eason (2), Mondays and Thursdays. Mr. Ormond (2), Tuesdays and Fridays. Operations (2), Tuesdays and Thursdays.

THE OUT-PATIENT DEPARTMENT.

The days and hours of attendance in the Out-Patient Department of the hospital are as follows:—

Medical Cases.—Dr. Hunt (1), Mondays. Dr. Cameron (1), Wednesdays. Dr. Hertz (1), Thursdays. Dr. French (1), Fridays. Dr. Poulton (1), Saturdays.

Surgical Cases.—Mr. Turner (1), Mondays. Mr. Fagge (1), Wednesdays. Mr. Rowlands (1), Thursdays. Mr. Hughes (1), Saturdays. Mr. Davies-Colley (1), Tuesdays and Fridays.

Obstetric.—Mr. Chapple (1), Mondays. Mr. Bellingham Smith (1), Thursdays.

Ophthalmic.—Mr. Eason (1), Tuesdays and Fridays. Mr. Ormond (1), Mondays and Thursdays.

Children's Diseases.—Dr. Cameron (1), Mondays; (9), Fridays.

Dental.—The Dental Staff (9) every week-day.

Throat and Ear.—Mr. Mollison (1), Tuesdays and Thursdays. Mr. Layton, Wednesdays and Fridays.

Skin.—Sir Cooper Perry (1), Tuesdays.

Electro-Therapeutic.—Dr. Hertz (1.30), Wednesdays and Thursdays.

Actino-Therapeutic.—Mr. Iredell (9.30), every week-day.

Orthopædic.—Mr. Trethowan (9), Tuesdays & Thursdays.

Nervous Diseases.—Dr. Hertz (9), Wednesdays.

Genito-Urinary.—Mr. Thompson (9), Wednesdays and Saturdays.

DENTAL SCHOOL.

The dental student is supplied at the Medical School Office with the Prospectus, Standing Orders, Notes on Probationary Work, List of Instruments, Calendar, and Clubs' Union Book.

These pamphlets should be carefully read in order that acquaintance may be made with the general arrangements of the school and the scope of the work upon which the student will become engaged.

Instruments having been purchased at a dental depôt, the student should satisfy himself that he has been supplied with all of those described in the hospital list.

Probationary work upon the phantom head will occupy the time for about two months. This operative course, conducted by the staff demonstrators, is very comprehensive. It includes most of the conservative operations that the student will subsequently be called upon to perform upon patients, namely, gold and other fillings, crowns, inlays, and the treatment of devitalized and septic teeth. These manipulations upon the dummy, when done in a thoroughly sound manner, form an excellent ground-work in operative dentistry.

Pupils in Dental Mechanics are received at the hospital, and a systematized and graded course of instruction is carried out by competent teachers.

The regulations of the Royal College of Surgeons of England require that students shall pass two professional examinations for the dental licence. At the first examination certificates must be produced, *inter alia*, of having been engaged in the practice of dental mechanics under a registered dental surgeon, or under the direction of the superintendent of the mechanical department of a recognised dental hospital, during a period of two years, and of having manufactured and adjusted six dentures and six crowns.

As this examination may be passed in the month of May, the work of the first winter session should be largely devoted to demonstrations, dental mechanics, and lectures.

Students in difficulties about their work and needing advice are invited to consult the Dean, or any member of the Staff, who will be pleased to do what they can to promote the interests of students.

SPECIAL DEPARTMENTS.

There are at present ten special departments in the Hospital, namely, Throats and Ears, Eyes, Skins, Gynæcological, Nervous, Children, Actino-therapeutic, Electro-therapeutic, Orthopædic and Genito-urinary. In all these departments the latest methods of diagnosis and treatment are to be seen, and much valuable information may be gained by the student.

The Choice of a Microscope.

Immediately on entering the hospital our medical student finds himself faced with a problem of serious import, although he may at the moment fail to recognise it as such, viz., the Choice of a Microscope. The present-day study of medicine necessitates the use o

the microscope from the most elementary stages until the moment when our fully-fledged medico leaves his *alma mater*, and, indeed, after that, if he is to put into practice the many aids to diagnosis which he has studied in the hospital laboratories. Occasionally it happens that he is already provided with an instrument of weird and wonderful design which served his forbears during the early days of microscopy, but such an instrument is useless at the present day. A comparatively simple microscope is adequate for the work carried out in the biology class, where our student first comes to hand-grips with the microscope, but it must be borne in mind that later, when studying histology, and more particularly when he embarks upon the study of bacteriology, a really sound instrument and first-class lenses become absolutely essential.

We would impress upon the man who enters the hospital totally unfamiliar with microscopical work, the fact that the services of his teachers, whose experience in microscopical matters is extensive, and has been quickened by the observation of difficulties encountered by past generations of students, are always at his disposal. There should, therefore, be nothing to prevent him from purchasing at the very outset of his student's career, a microscope stand of thoroughly sound construction, and of such a pattern that the additions necessary to fit it, even for research work, can be added from time to time as the necessity arises, at comparatively small cost.

Although some twenty or thirty years ago Continental makers were unrivalled in the manufacture of microscopes, and still retain much of the reputation they then gained, yet at the present day the stands made by some of the British firms are undoubtedly superior in materials, workmanship, and attention to constructional details, and we would strongly urge the purchase of a stand of English manufacture; such for example as the Stand H (Edinburgh Students) made by Messrs. Watson & Sons, 313, High Holborn. This is of the tripod pattern, jointed, provided with a rack work, coarse adjustment, fine adjustment of the lever type, large stage, with square opening, fitted with mechanical movements, compound sub-stage (to which additional apparatus may be attached in the future), and a swinging double mirror, plane and concave, and costs about £10. The addition of a 1in. lens, a $\frac{1}{6}$in. lens, and two eye-pieces, one magnifying two diameters, the other eight, at the cost of about another £3, provides the student with an instrument which will prove a faithful friend during the preliminary studies of biology and physiology. It will also serve him for his morbid histology, and when he enters the bacteriological class he will merely need to add an Abbé sub-stage condensor, costing from 15s to £1, a triple dust-proof nosepiece, £1, and a $\frac{1}{12}$in. oil immersion lens, which will cost him a further £5. Practically all the standard makers put a really good immersion oil lens upon the market at this figure, the best being those supplied by Watson & Sons, Crouch (Agents, Messrs. Maw, Son & Sons), and the Continental firms of Zeiss, Leitz, and Reichert.

In chosing a microscope it is not always true economy to obtain the entire equipment from any one firm; and it may be well at times to get a stand from one maker, the lens from another, the second lens from a third, and so on, for all lenses, etc., are made to standard screws, therefore accessories manufactured by different firms are interchangeable; and in this connection the expert knowledge of his teachers in the medical school is so valuable to the student.

Such a microscope as we have sketched out is the ideal from the point of view alike of the student and the teacher; but in some instances the initial cost may be greater than the student cares to incur, and if this is so, he will find that nearly all the reliable firms make less costly models, which will serve his purpose. For a student's microscope of proved reliability, Messrs. Watson & Sons' "Stand F" and "Fram" models are to be recommended; these instruments, with 1in. and $\frac{1}{6}$in. objectives, eye-piece, and case cost £7 17s. and £6 5s. respectively.

Or again, the student may occasionally be able to acquire a good second-hand microscope comparatively cheaply, but such an instrument should never be purchased unless he can obtain it on approval, and submit it to expert opinion before completing the purchase, especially if the microscope is to be obtained from a pawnshop or second-hand dealer. A good plan, often productive of marvellous bargains, is to enquire of some first-class firm whether they have an instrument of their own make for disposal second-hand, as it sometimes happens that a microscopist disposes of a particular microscope in part-payment for a more expensive model, and in this case the purchaser of the second-hand instrument obtains the guarantee of the maker that the microscope is in good condition. Second-hand lenses may also be picked up occasionally; Messrs. Baker & Co., High Holborn, and Messrs. Millikin & Lawley in the Strand, usually have a good selection of second-hand lenses. Slide boxes or cabinets to contain finished slides can be obtained of any of the microscopical instrument makers, the nearest being Messrs. Stanley, whose place is close to London Bridge Station.

Instruments.

In the dissecting-room and physiological laboratory, the student will require a set of instruments. This consists in some scalpels (the best being those made entirely of steel), a pair of non-toothed dissecting forceps, a large and a small pair of scissors, a probe, a blowpipe, a set of chain-hooks, and a small oil-stone on which to sharpen the knives. In addition, the various accessories for microscopical work will be required, viz., a gross of glass slips, an ounce of small and large cover glasses, a bottle of Canada balsam. three needles mounted in handles. and a box in which to keep the finished slides.

The dissecting instruments can be procured from any of the big London Makers; Messrs, Down Bros., opposite

to the main entrance of the hospital, have a large and very varied stock from which one may select, whilst other famous firms are:—Allen and Hanbury, Wigmore Street; Maw and Sons, Aldersgate Street; Arnold, near St. Bartholomew's Hospital; Bailey, Oxford Street, and the Holborn Surgical Instrument Company, Thavies Inn, Holborn Circus. The latter firm sell some instruments that are rather less expensive than the usual ones. Microscopical accessories can be procured from Messrs. Stanley, London Bridge Railway Approach, or from Baker, of 244, High Holborn, or from Watson and Sons, of 313, High Holborn: all these firms not only hold a large stock of these necessaries, but are also specialists in all kinds of optical apparatus, e.g., microscopes, blood-counting apparatus, ophthalmoscopes. cystoscopes, spectroscopes, etc.

In the surgical wards, a new set of instruments will be required. As a surgical ward clerk, the student will only need a steel 60-inch tape, a skin-pencil, and a pair of ordinary round-nosed scissors, for cutting off dressings. A stethoscope, though occasionally desirable, is not really necessary to him, and its choice had much better be deferred until he becomes a medical ward clerk, when some skilled person will assist him in the choice of the most appropriate kind. When the student attains the dizzy eminence of a dresser, he will need a full set of dressing instruments, which comprises:—2 or 3 Spencer-Wells artery forceps; a pair of dressing scissors; a sinus-forceps; a scalpel and abscess knife, combined; a trocar and cannula, for hydrocoeles; a probe; a caustic holder; some curved and straight cutting needles, including a few of small size; a Bryant's dressing forceps.

In addition, it is very useful, though not absolutely essential, to have a pair of fine-pointed scissors, to be kept for the sole purpose of removing stitches. All these instruments should be of the finest quality procurable, as otherwise they will never withstand the rough and constant use to which they will be subjected in two or three years' work in the wards. In the medical wards, and in the eye wards, an ophthalmoscope is practically a necessity, and the student is strongly advised to consult one of the Staff before purchasing one; an inferior instrument costs but little less than one of the best, and is often a constant source of annoyance, even if it be not quite useless. A first-class "Morton" is the only kind worth having.

Books.

The student who wishes to obtain his books at once should not take the first he sees on any particular subject, but would be wise to consult his demonstrators first; the number of text-books is very large, and the choice is a difficult matter to the inexperienced. Roughly speaking, second-hand books are very seldom worth anyone's while to buy, chiefly because medical science is progressing so rapidly that new editions are constantly being published.

The number of publishers of books for medical students is great. Messrs. Churchill publish Taylor, Jacobson, Goodhart, Fagge, and many other well-known works. Messrs. Macmillan publish Allbutt, Foster, and a great number of first-year books; Messrs. Longmans, Green & Co. publish the famous Gray's Anatomy. Mr. H. K. Lewis, 136, Gower Street, publishes a number of medical books, and has also a medical circulating library which is valuable to students who wish to see all the latest books. Mr. Murray also publishes many well-known medical books, as also do Smith, Elder & Co.; Philip & Son; Cassell & Co.; Nisbet & Co.; and Baillière Tindall & Cox.

As we have mentioned, it is rarely that second-hand books will be required, but there are cases in which they are valuable. Mr. Chas. Sawyer, 29–31, New Oxford Street, W.C., has a long list of last editions at very moderate prices, and there are other second-hand booksellers.

All books can be obtained from Mr. H. H. Grattan, in Borough High Street, who is the "official bookseller" to the hospital. Many well-known books he can supply over the counter; any others desired he will have in an hour or two.

Osteology.

The question of the purchase of bones is always an important one. Millikin & Lawley, in the Strand, make a speciality of supplying the medical student with this part of his equipment.

Guy's Hospital Clubs' Union

The Formation of the Clubs' Union, by the amalgamation of the various constituent institutions, took place in the summer of 1891. The objects of the amalgamation are to further the interests of the clubs and societies existing at the hospital by their mutual support, and to simplify the collection of subscriptions. By the payment of an annual subscription (see Clubs' Union Year Book, p. 13) to the Clubs' Union, any student of the hospital can obtain the privilege of membership of the constituent institutions.

The Ground of the Clubs' Union, which is under the control of the council, is situated close to Honor Oak Park Station, on the London, Brighton and South Coast Railway, and to the Crofton Park Station on the South Eastern and Chatham Railway. It is nine acres in extent, and is the headquarters of the Guy's Football, Cricket, Athletic and Lawn Tennis Clubs. Return tickets at single fare are issued by the Brighton Railway Company. Under such restrictions as are found necessary by the committees of the several clubs, and are approved by the council of the Clubs' Union, every member of the

Union has opportunities of practising and taking part in matches, and in the various sports and games. There is a large pavilion upon the ground, with dressing and lavatory accommodation. Refreshments can be obtained by members of the Union according to the tariff of the Students' Club.

CONSTITUENT INSTITUTIONS.

The Cricket Club; The Football Club; The Lawn Tennis Club; The Golfing Society; The Hockey Club. Details of these have been omitted as no officers have been elected this year on account of the war.

THE PUPILS' PHYSICAL SOCIETY.—Hon. President: Sir James Goodhart, Bart., M.D., LL.D. Hon. Vice-Presidents: Frederick Taylor, M.D.; Sir Geo. H. Savage, M.D.; C. J. Symonds, M.S. Hon. Secretaries: G. T. Mullally, M.B., B.S.; T. B. Heaton, M.B., B.C.

This flourishing society was founded in 1830, on the plan of the old Physical Society, which existed during the latter part of the eighteenth century at Guy's Hospital.

At the Pupils' Physical Society, which meets each fortnight on alternate Wednesday and Saturday evenings, a paper on some subject, not necessarily of medical interest, may be read by any member, to be followed by a discussion. "Clinical" and "Pathological" Evenings are devoted to the exhibition and discussion of interesting cases or specimens which may be shown by any member. The society offers a prize of £5 to the member who distinguishes himself most in the discussions; and a prize of £5 to the member who exhibits the best specimens of scientific interest during the session.

THE DEBATING SOCIETY.—President: L. E. Shaw, M.D. Vice-Presidents: J. Fawcett, M.D., A. W. Ormond, F.R.C.S., H. C. Mann, M.D., M.R.C.P., A. R. Thompson, F.R.C.S., T. B. Layton, F.R.C.S. Hon. Secretaries: G. Neely, and T. L. Heath. A committee of the Secretaries and six students.

Members of the Clubs' Union, junior as well as senior, are specially invited, in their own interests, to attend as many as possible of the meetings of this society.

The endeavour has been made to choose subjects within the scope of the limited interests of the medical student, and it is hoped that all will try to be present who are not too blasé to listen to the views of others, or too slack to give others the benefit of their own.

The list of debates will be published in the GAZETTE; anyone willing to take part is particularly requested to communicate with the Secretary.

THE DENTAL SOCIETY.—President: L. D. Wright, Esq. Hon. Secretary and Treasurer: E. P. Deverall.

The object of this Society, which was founded in 1894, is the promotion of interest in Dental subjects, and the discussion of Dental topics. Papers are read before the Society each month, and a prize (value £5) is awarded for the best paper read before the Society during the session. Casual communications are invited at all meetings, and a prize (value £1) is awarded at the end of the session for the best set produced.

One meeting during the session is set apart for the examination and discussion of cases of special interest, the patients being brought up for examination.

The meetings are held every month during the winter session in Class Room No. 2 in the Medical School Buildings. The meetings take place at 5 p.m. on the second Tuesday in the month, and tea is served before the meetings for members attending the meetings. New men are strongly urged to attend and take part in these meetings, which, in the past, have proved instructive as well as interesting.

THE GUY'S HOSPITAL REPORTS.—Edited by F. J. Steward, M.S., and Herbert French, M.A., M.D.

The Reports are published annually, and each subscriber to the Clubs' Union is entitled to a copy, which he may obtain in the Wills Library from the Librarian. Each volume contains papers by members of the Staff of the Hospital and Medical School upon original work done in the Hospital during the preceding year; it also contains a list of the gentlemen who have been educated at Guy's Hospital, with the appointments they have held during the year, the examinations they have passed, and the prizes and honours they have won. The first volume appeared in 1836; copies of the earlier volumes can be obtained from the Editors. The value of this annual publication is obvious, and every Guy's man is proud of the original papers of its Staff, from those of Addison, Bright, and Hodgkin, to those of the present day.

THE STUDENTS' CLUB.—Officers—President: W. Hale White, M.D.; Treasurer: John Fawcett, M.D.; Hon. Secretary: N. Mutch, M.D.; and a committee of eight.

The above named manage the affairs of the Club, a full account of which will be found in the Clubs' Union Blue Book.

GUY'S HOSPITAL CHORAL SOCIETY.—This Society will begin rehearsals for the Winter Season early in October The practices are held every Friday, at 5 and at 8 p.m., in whatsoever room shall be deemed convenient for the occasion. Notices are posted on the screens opposite Astley Cooper door, in the Dissecting Room, and in the Students' Cloak Room, Medical School.

Since the success, and, indeed, the very existence of the Society depends entirely upon the keenness and

enthusiasm of those students who are musically disposed, it is hoped that all freshmen who have voices, or other musical talent, will announce the fact by their presence at the rehearsals.

All particulars may be obtained from the secretaries, H. Q. F. Thompson and J. J. Sterling-Hill.

BOXING, FENCING AND GYMNASIUM CLUB (The Pavy Gymnasium). President: H. L. Eason, Esq., M.S.; Treasurer: W. M. Mollison, Esq., M.C. Committee: Messrs. G. T. Mullally, Faskin, Portway, Maelzer, E. A. Leviseur, Coe, and Whitten. Hon. Secretary: F. W. Stiven.

The Pavy Gymnasium, which was built and endowed by the generosity of the late Dr. Pavy, is situated in the Quadrangle of the College, and is open to members of the Clubs' Union at all times.

Throughout the winter session, classes conducted by thoroughly competent instructors are held weekly in boxing, fencing and gymnastics. An excellent wrestling mat has recently been acquired by the club, and if there is sufficient support an instructor in wrestling may be engaged. At the end of the winter session an Annual Assault-at-Arms is held, and a team selected to compete in the Inter-Hospital Boxing, etc.

All men who are interested in this club are earnestly requested either to make themselves known to the Secretary or to one of the Committee, or to turn up to the Classes in the Gymnasium at the advertised times.

Serbia.

I.—THE RUSKI ZAR.

My first sight of the Ruski Zar I shall not easily forget. I had been travelling all night in an unlighted, unwarmed second-class compartment. The long tramp which separated the station from the nearest signs of civilisation was several feet in mud. From the heavens poured a penetrating mixture of rain, snow, and hail. The dawn, just breaking, seemed to heighten the dull misery of breakfastlessness. On such a morn even Shelley's lark would be a dispirited fledgling.

At its best Nisch is not an inspiring town. One could imagine the inhabitants spending their holidays in an Engilsh colliery district by way of a pleasant change. Think of the largest and most straggling French village you know, picture its condition before the revolution, and pour one foot of mud on all its streets, and you have some idea of Nisch.

Several miles further on (or at least it felt like that) I came to a café filled with Albanians, a few pedlars, and the relics of the Serbian army. Among these my entry caused a lively stir, but seemingly the waiter had struck. At all events I emerged unfed, but a little faint. On an empty stomach the odours of a caravanserai are apt to have distressing results. Long afterwards I sighted a cab on the horizon. I hailed it with the emotions of a shipwrecked mariner. "A café, a hotel!" I cried, "somewhere, anywhere to be dry and warm!" "Dobro," said the jehu, settling his cloak around his shoulders, and with a lunge, a roll, and a splash the rackety vehicle started through the mud.

There was something in the atmosphere of the Ruski Zar which distinguished it from mere lack of ventilation, excess of carbon dioxide, overcrowded humanity. Stuffiness, as such, is a thing which men avoid, finding it depressing and vaguely unpleasant. The air of the Ruski Zar, on the other hand, seemed to have a subtle attraction which, in the end, became as stimulating as a secret vice. The French word *faisandé*, which means primarily "high," and thence "decadent," expresses as nearly as may be its quality. Passing its little swing doors that flapped viciously at your coat-tails, your first impression would be one of overpowering heat, to which you had to grow accustomed as the eye to light. Gradually other impressions, the ghosts of repasts long buried in a decent obscurity, the sickly perfumes of chromatic confectionery, of weird liqueurs, the fumes of spiced wines and lager beers, the pungency of crude tobacco, the odours of the richly various clientèle, rose and floated round you in a sort of spell. It time it became an opiate in which one flourished with the unhealthy precocity of a hot-house flower. The waiters smiled wanly as the new-comer clamoured indignantly for air; in a week you would see him shuddering like the rest as he passed by the hermetically-sealed windows.

The din is terrific. Raucous shouts of "Kellner," echoed as "Odmach," a cry as meaningless as the Italian "Subito," the English "Coming, Sir"; the vendors of the "Ruski Slovoe," or the "Novo Politik" journals which run through seventeen editions per diem; the hawkers of pea nuts and paprika who worm their unsavoury bodies among the tables depositing a sample of their wares as they pass; the clapping of hands; the buzz of talk; the incessant jangle of crockery; assail the ear as a harsh crescendo of sound.

Fierce officers, their faces covered with grog-blossoms, shriek for "chi!" which, being interpreted, is that innocuous beverage, Russian tea. Mothers offer their little Sonyas or Petarrs sips of the fiery slivovitza (plum brandy) thinking, as one told me, that it will strengthen their stomachs. A motley crew of Greeks, Armenians, Bosniaks, Turks, and Bulgars demand (and get) their native form of alcohol.

As feeding time approaches, the clamour seems to grow louder, prospective diners beat angrily upon the tables, demanding viands which they know full well will not be served before seven, for such is the in-

exorable rule. Some benighted foreigner arrives, and the bewildered waiter sends up a shout of "Petrović." In an instant he is there, Petrović the bland, the sardonic, the debonair. Paragon of a Bayswater boarding house, pride of the Hotel Chatham, how come you here amidst the frowsy napery and uncleaned plate? Serene, imperturbable, amidst this uproar of Babel, he takes the lost one under his wing, and talks to him in his own tongue; alas! too soon he left us, disgusted, as he explained, with the untutored ways of the customers.

In speaking of the *cuisine* of the Ruski Zar, one is reminded of the traveller who dismissed a tribe thus briefly:—manners, none; customs, horrid. It was a thing to contemplate more in sorrow than in anger. Thus, for example, if you ordered roast lamb, your plate would arrive loaded with an entire forequarter; a plate of Tchorba (chicken soup) contained the bird as well, which you were subsequently expected to demolish with the implements of nature.

Keebub, the national delicacy, consists of small fragments of mutton, transfixed with a skewer, and roasted over a charcoal fire, the whole then being garnished plentifully—as Mrs. Beeton would say—with raw garlic. *Pilaf*, a dish imported from Greece, is too well known to need description. *Paprika*, the dried pods of red pepper, is much esteemed as an appetiser, and it is a standing marvel to the traveller to see a native eat a dozen or so of these fiery berries without a qualm. In an unguarded moment I ate a morsel, and was seized with a desire to drink up Iser. Certainly no Serbian need fear the life to come.

Like all primitive peoples, they have an intense love of gaudy sweetmeats which finds expression in vast and indigestible masses of confectionery known as *Kolatché*. The table linen which seems to be a mere concession to Western ideas, is never changed. A Chauvinistic waiter, to whom we once complained of it, advanced the plea that as they were a comparatively young nation, it would be unreasonable to expect them to trouble with mere matters of detail—a hypothesis which, as my form master used to say of my renderings of Vergil, seemed ingenious, but incorrect. Space does not permit me to tell of the many types who foregathered round the grimy tables every night after their day's work amid the typhus stricken hospitals.

Marković, gentlest of doctors, who fell sick two days after his appointment as chief to a new hospital, *le petit Vlastos*, who, in the throes of nostalgia would regale us with brave tales of Bullier's and the Boul' Mich'; Ohanian, an Armenian, who inhabited Willesden in order to live near Gladstone Park. "You see," he confided, "for us we thought Gladstone would do so much." I suppose people live at Willesden for reasons even less substantial.

G. H. F. G.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Notes on Dental Metallurgy. By W. Bruce Hepburn, L.D.S., Lecturer on Dental Metallurgy, Glasgow Dental Hospital and Examiner R.F.P.S., Glasgow, etc. Second edition. London: Ballière, Tindall & Cox, 1915. 252 pp. 6s. net.

We have great pleasure in welcoming the second edition of this little book. The fact that the author is a dentist, and regards the subject and its difficulties from a dentist's point of view, is in itself a great recommendation.

More attention is given to the preparation of the various metals than is the case in most other books, and the properties are arranged in a definite order. The composition and properties of the various cements have been touched upon, and the chapter upon that most important metal, gold, is excellent.

The student will find that a perusal of the chapter on constitution of alloys will remove many of his difficulties. Considerable attention has been devoted to amalgams, but we might suggest the future addition of a short analytical table, as this is often required in examinations. The report on "Structural and other changes arising in connection with metals used in the mouth," delivered by the author before the Sixth International Dental Congress, should prove of interest to practitioners as well as to students. The appendix, comprising formulæ for alloys, solders, etc., should prove very useful to those who make their own alloys. We have much pleasure in recommending this book to students and practitioners, and we feel sure that it will achieve the great success it deserves.

Birth.

ATKINS.—On August 24th, at Sixpenny Handley, Dorset, the wife of F. R. Louth Atkins, M.R.C.S., L.R.C.P., of a son.

Marriage.

WILSON-SMITH—STORY.—On September 2nd, at the Parish Church, Bromley, Kent, Thomas Wilson-Smith, M.D., M.R.C.P., of The Circus, Bath, to Louisa, daughter of the late Rev. George J. Story and Mrs. Story, of Holligrave Road, Bromley.

Death.

FERRABY.—On July 8th, 1915, H. P. Ferraby, M.D., at 40, Mansfield Road, Nottingham.

E. N. G.

GUY'S HOSPITAL GAZETTE.

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Passim.

AT the Court of Governors held last week, the President announced the death of Captain the Honourable H. H. Molyneux, R.N., one of the Governors of the Hospital. A vote of condolence was passed to the Honourable Mrs. Molyneux. So Guy's has lost another of her Governors, who, from the day of his election in 1905, always took a keen interest in the Hospital until latterly, when his health began to fail, and he was unable to visit the Hospital as frequently as he would have wished.

We would like to extend our sincere sympathy to the Honourable Mrs. Molyneux, who has been indefatigable in her work as a Lady Visitor to the Wards.

Another Guy's man, Lieutenant Edgar Faulks, R.A.M.C., must now be added to our Roll of Honour. Edgar Faulks came up to Guy's from Nottingham University College in October, 1897. He qualified M.R.C.S., L.R.C.P., in October, 1902, after being Clinical Assistant to Dr. Frederick Taylor and Sir Cooper Perry. He then became Assistant House Surgeon to Mr. Steward, and later House Surgeon to Mr. Lucas. During the last four years, he had been Senior Medical Officer at Bexley Asylum, Kent. In July he joined the Royal Army Medical Corps, and left for France a few weeks ago, where he met his death on September 27th.

ONCE more the builders are at work in the Hospital. The Dining Hall in the Nurses' Home we believe is being enlarged to hold forty more nurses. A new building is being erected between the east end of "Clinical" and the Colonnade steps, which we believe is to serve as a waiting room for the patients of the Massage Department. We can well imagine the many covert glances of envy which will be cast into this room by, House Surgeons, House Physicians and their firms as they tramp the wind-swept Colonnade on an icy cold winter's day, smoking countless numbers of cigarettes as they wait for their respective Chiefs.

IT is a long time since we have received any letters from men abroad for publication in the GAZETTE. It must be extraordinarily difficult for them to find time for letter writing, but we would like to remind them that, if they do have the chance of writing, we would welcome their letters warmly. Copy has never been more difficult to obtain for the GAZETTE, and we hope that all subscribers will send along any news which they may think interesting, for publication. The GAZETTE has yet another trouble to face; it is threatened with "penny postage," and if this comes into force we must try and get "our moneys worth" by collecting extra large supplies of copy.

To Dr. P. P. Laidlaw, M.A., B.C., falls the honour of being the first Lecturer to hold the Sir William Dunn Lectureship on Pathology. We offer him our hearty congratulations.

Below we give a list of the fixtures which have been arranged for "A Guy's XV." during the coming season. There is no doubt that there will be considerable difficulty in raising this team, but we hope that all men who are keen for a game will try and keep these days free.

Sat., Oct. 30, 1915.	v.	R.N.A.S.,, Wormwood Scrubs, at Wood Lane.
" Nov. 6	... v.	R.M.A., at Woolwich.
" " 20	... v.	Bart.'s, at Winchmore Hill.
" " 27	... v.	R.M.A., at Woolwich.
" Jan. 8, 1916.	v.	R.N.A.S., Wormwood Scrubs, at Honor Oak Park.
" Feb. 5	... v.	Bart.'s, at Honor Oak Park.

An Extraordinary General Meeting of the Students' Club will be held on Tuesday next, October 12th, at 4 p.m., in the Physiological Theatre.

Agenda.

1. To read a letter from the College Committee concerning the Catering Department.

2. Mr. Muir Smith to propose:—That a larger Advisory Committee in Catering, than the present one, shall be elected by the Students' Club.

3. To elect a member to serve on the Advisory Committee on Catering, in the place of Mr. Long, in the event of the rejection of Mr. Muir Smith's proposal.

Men residing in the College especially should attend this meeting, at which they will be able to air grievances and put forward suggestions.

THIS WEEK'S "STRAAFE."

It is not our custom to carry on petty warfares, but we cannot help having a small "hit" this week. Below we append a paragraph taken from a Students' Number of one of our contemporary Hospital Journals.

> "We congratulate all new students upon having selected ——— Hospital as their *Alma Mater*, because not only is it the senior London hospital, with a history dating back some 800 years, but it undoubtedly possesses the finest traditions and the highest examination records, particularly in surgery, in which subject it is approached by no other hospitals, however excellent they may be in other respects."

How can we possibly compete against such an ideal place?

The words "finest traditions and highest examination records" literally took our breath away. Take us and show us these marvellous fantasies, and when we have seen them with our eyes, then shall our tongues either cling to the roofs of our mouths or utter "Truly this is a wondrous place!"

From the same Journal "The Cricket Club is of course not active during the winter." Of course not. A perpetually sodden wicket is not fair on the batsmen, and the "studs and bars" which the bowlers would need for their boots, would "hack up" the pitch horribly. Besides, Rugger, Soccer and Cricket during the winter, would surely affect the records!

Yet again, as an exhortation to the new students, "Another Lord Lister or Poet Laureate may be amongst you." Ah! have we found the clue to the "highest examination records"? Do they imply that Medicine is not the one and only subject in which they set up records?

HEARD IN OUT-PATIENTS.

Scene: A Dresser walking about Out-Patients waiting for his Surgeon, Mr. ——, to arrive.

Patient: "Please sir, would you mind attending to me now? I must get away early, I am terribly busy with my work."

Dresser: "No! I am sorry, but you must wait till Mr. —— arrives."

Patient: "Oh, no, Sir, that don't matter a bit! and Mr. ——, 'e don't mind the Dresser attending to me. You see 'e knows I am a busy man and that I can't leave my work for long, so 'e told me to ask yer if I sees yer."

Dresser (having visions of busy munition workers, shellmakers, etc.): "What is your work?"

Patient: "Me, sir? Oh, I'm an Undertaker."

FROM EYE OUT-PATIENTS.

"Well, Mother, how are the eyes?"

"Well, sir, I've started seeing green stripes, I 'ave. It's like this, sir. Last Sunday I goes to church and sees the parson come in, but he seemed to have some green things over his white uniform, so I thought they must be some new regalia. Then I notices the choir was all the same, so I thought it funny that they should be wearing regalias too, so I 'ad another look, but they were still there. Then I 'appened to see a lady wot lives near us, and she 'ad green stripes down 'er white blouse too. So arfter the service, I goes and asks her about her blouse and she said it was white. Now, what d'you think abart it, Doctor?"

Papers by Guy's Men.

Capt. H. G. Gibson, R.A.M.C. : Some Notes on the use of Sensitized Streptococcal Vaccine in Infected Gunshot Wounds, and a Report on a Case in which it was used.—Journ. of the R.A.M.C., June, 1915.

Lieut.-Col. E. M. Pilcher, D.S.O., R.A.M.C :—Notes on Professor Dr. M. Kirschener's Paper, "Remarks on the action of the Regular Infantry Bullet, and the Dum-dum Bullet, on the human body."—*Ibid.*

Capt. H. Watts, M.D., I.M.S., :—Some Experiences of the War.—*Indian Medical Gazette,* Sept., 1915.

Sir James Goodhart, M.D., LL.D. Aberd., F.R.C.S. Lond. :—On Nervous Furring of the Tongue, and disturbed taste.—*Lancet,* September 25th, 1915.

H. Gardiner, M.S. Lond., F.R.C.S. Eng. :—Tonsils and Chronic Cervical Adenitis.—*Lancet,* Oct. 2nd, 1915

E. C. Hughes, M.C., F.R.C.S.:—Diagnosis of Ulcers of the Tongue,—a clinical lecture given at Guy's Hospital.—*The Dental Record,* October, 1915.

W. Burridge (Proceedings of the Physiological Society, July 3rd, 1915) :—I. Some Points concerning the Sartorius Muscle. II. Note on the use of Cane Sugar in Perfusion. III. Note on Cardiac Excitability.—*Journal of Physiology,* August 31st, 1915.

Montagu F. Hopson, L.D.S. Eng., F.L.S. :—Apes to Modern Man (II.).—*British Dental Journal,* 1st October, 1915.

A. W. Ormond, F.R.C.S.:—Iritis,—a clinical lecture delivered at Guy's Hospital.—*The Practitioner,* October, 1915.

W. M. Mollison, M.C., F.R.C.S.:—Acute Mastoiditis,—a clinical lecture delivered at Guy's Hospital.—*Ibid.*

Serbia.

II.—SKOPLJE.

"The addition of strangeness to beauty constitutes the romantic."—W. Pater.

The moon rising yellow and enormous over the western heights shows a panorama of pure beauty. Sweeping down from the ridge runs the silver ribbon of the road. Yonder, beyond the hills, the mountains, white and shimmering, culminate in a lonely pinnacle. It is Shar Dagh, the highest point of the Balkan range, seemingly within an hour's march, though in reality fifty miles and more to the northward. Pure and solitary, it seems to contemplate with a compassionate virginity that little thing of clustering lights and shadows which is the town of Skoplje.

Away there in the hollow half a score of minarets, like ghostly fingers, point aridly to heaven, and the domes of mosques gleam dusky under the lustrous night. From beneath us rises a murmur like the breathing of a sleeping child, broken only by the howling of a dog in the Turkish quarter near at hand, yet softened by the distance, till it, too, hardly mars the stillness. Slowly the moon illuminates the plateau and our eyes distinguish on the slopes a field of giant mushrooms, tumbled fungoid growths like the vegetation of some lunar wilderness. It is a disused Moslem burial ground, and approaching, one notes the slender wistfulness of its decaying stones and the spidery epitaphs commending to the lap of Allah some long departed. The whole impression is one of fragility, not a little pathetic. Such is Skoplje, seat of pest and corruption, mellowed by distance, and purged by the infinite charity of night.

Even by day the Moslem quarter—and this is by far the most considerable part of the town, which until 1912 was a Turkish city—retains much of the whimsical charm of the East. The Serbian half, a garish, squalid region, stretching from the Vardar, a swiftly flowing torrent of pure mud, to the station, combines modernity and insanitation to a degree only possible to a nation trying to forget its Orientalism under a gloss of culture from Vienna and Buda-Pesth. But in the older district, pushed and jostled amid the motley crowds which frequent its tortuous alleys, one feels at once the influence, the fierce and immemorial conservatism of the Moslem soul. Here in a heterogenous medley the Turk, cross-legged and fezzed, plies his various occupations with a philosophic unconcern. It is the negation of activity, yet, withal, alive with a certain *dolce fa niente* vitality which ruffles prevailing calm like a breeze rippling an oily sea. Dignified and prophetic, little groups squat chatting on the raised frontages of their shops. As they argue,

rich in gesture and intonation, they flick with long, graceful fingers the ash from innumerable cigarettes. The profound cynicism of the Orient is on every line of their features. Little boys with olive faces and black, dancing eyes, flit from cluster to cluster, bearing glasses of water and diminutive cups of coffee on strange tin-handled trays. Without pausing the talkers drain them off and place them back on the trays. The host alone seems to be occupied, sewing with a careless diligence in long, sweeping strokes. At the corners and leaning against the doorposts more little boys take the air, their red fezs tilted at a rakish angle, and, as the Christian dogs pass, spit with supreme disdain.

The chance juxtaposition of a dozen occupations, each with its gaudy pile of merchandize, lends the streets a striking air of chromatic contrast. Next, perhaps, to the bootmaker with his show of opankés, brilliant blues, and vermilions, delicate confections of pierced and embossed leather, comes the haberdasher, his windows bright with printed cottons from Bolton and Bengal, or the carpet weaver faking designs from Bokhara and Tiflis for the chance tourist. The hardware stores are gay with meretricious pottery, doubtless from Brummagem or Stuttgart, yet in its crudity not a little fascinating. At the cookshops, tall Albanians, come from heaven knows where, crowd round a steaming haunch of beef or a lamb roasted whole. The chef, sharpening the huge knife which hangs from his girdle, proclaims his fare with a monotonous cry, and with a deft gesture fills the topmost of a pile of platters at his side. The nearest of the Albanians takes the plate, and, extracting from his belt a formidable dagger, cuts the meat into small pieces which he impales upon its point. As he eats, one notes the build of the man, his close-cropped fair hair, covered by the white felt skull cap which forms the national head-dress, his upright, loosely-knit frame on which the dingy cream-white jacket hangs as though made for some smaller brother. Beneath is a woollen vest, garnished with brass or pearl buttons and decorated in all shades of blue, crimson, and yellow. Below the dagger belt, containing, as a rule, two antiquated horse-pistols, a pouch of money, and a business-like poignard. The breeches, too, are white and fit tightly just below the knees, where their colour is relieved by bright, knitted stockings, whose hue forms the hall-mark of the Albanian "nib." The footwear, universal throughout the Balkans, is the *opanké*, consisting of a piece of leather, bent in at the toe, sides, and heel, and bound in position by crossing thongs of leather, which interlace as far as the middle of the calf. Shoes such as these (you can see their like worn by the peasantry in Early English decorated M.SS.) seem, according to their wearers, to combine comfort, durability, and inexpensiveness to a remarkable degree. At the beginning of the war an attempt was made to equip the Serbian army with regulation boots; in three months every man was wearing opankés again and performing prodigious marches in the almost impassable mountain districts in them. To the uninitiated, their great disadvantage seems to be the radical impossibility of keeping one's feet dry; perhaps, however, continued use accustoms one to this defect.

Next door the baker exposes his ovens to the light of day. On the flat frontage of his shop are piled appetising little kolatché, guarded jealously by a cross-legged urchin who hurls insults at the children who eye them greadily, thumb in mouth. The baker, a swarthy fellow sketchily attired, rakes the pungent wood ashes from the yawning mouth of his oven, and pushes flat brown loaves into the interior. From time to time he removes the stone covering the opening of one by the side, and with a sort of elongated trowel fishes out a loaf from the interior and prods it with a trident. Then, shaking his head, he puts it back again. The method is primitive; you can see ovens of the same kind in Pompeii and Hurculaneum, and the bread they produce is leaden and doughy.

To the casual observer it seems remarkable that the Serb has any digestion left after the age of thirty. The bread alone would make a chronic dyspeptic of most people. Owing to the scarcity of flour, it is made of a fearsome mixture of rye, acorn meal, and maize; in the baking it becomes so heavy that I have seen an Austrian prisoner inflict grievous bodily hurt on a comrade by simply throwing his daily loaf at him. Yet wounded and fever patients flourish on nothing but this and cold water. The food is so highly spiced as to be unpalatable to the Westerner, and is nauseous with added fat. Lard, as a rule, takes the place of butter. So great is the love of sour dishes that crude oxalic acid is sometimes placed in the food to render it sufficiently rancid. The love of sweetmeats and red pepper I referred to in a previous article.

Moreover, the Serb, without the American excuse, has developed an appalling habit of water-drinking, tossing off three or four tumblersful at any time of the day or night. Without agreeing with the alcoholics' view as the probable physiological action of water on the stomach, one is at least free to wonder if a habit such as this is likely to benefit the system in the long run. Certainly most middle-aged Serbs I saw seemed to be in extraordinarily bad condition. *Mais revenons à nos moutons.*

Perhaps of all the weird medley, the dress of the women lends most to the idea of remoteness. One is so accustomed in Western literature to reading of the dress of Turkish women, the flowing pantaloons, the dainty slippers, the loose-sleeved jacket, the yashmak or veil, that to see them with the eyes of the flesh for the first time gives one a shock of uncanny familiarity. Moreover, I had the impression, though whether it sprung from a revue or an early love of Pierre Loti I cannot say, that Turkish women were invariably

beautiful, voluptuous creatures, nursing the *grande passion* in the discreet seclusion of the harem. I suppose subconsciously most people have a delusion of this sort. Judge, then, of my disgust at finding the streets full of raddled old hags whose loosely adjusted veils revealed the grimy seams of years.

All the elements of romance are ready. Now little peeping jalousies, pale green against a background of cream or chocolate, thickly curtained, breathing the secrets of a thousand charming mysteries; now the courtyard of some old caravanserai where one looks in vain for the pack-ass of the Arabian bagman, or the tower of a minaret sharply silhouetted against the evening sun, yet from whose height no muezzin sounds summoning in prayer the faithful. Once, and once only at dusk by the crumbling walls of an old garden spangled white with apple blossoms, two black-robed figures, heavily veiled, stole forth to evening prayer. As they rustled past with quick twinkling steps I caught a glimpse of eyes adorably young and after them a faint perfume came down the breeze. I never saw them again. I am glad—preserving thus the glamour of a conjectureful ignorance.

In the Serbian quarter one finds little but dirt and a teeming fecundity. In a primitive sort of way there is an attempt at civilisation; electric light which has to be economised to such a degree that after dark it serves to accentuate rather than relieve the darkness; a picture-palace or two where Max Linder and Prince go through the antics of three years and more ago; a pretentious "gymnasium"—it was our hospital—unfinished and utterly unsanitary, which towers over the surrounding hovels with an air of meretricious brightness. Down by the river there is a house or two which might have been transplanted bodily from the Paris *banlieu*, standing, rococo and inappropriate, in a pleasaunce of offal. Near the bridge the gaiety is enhanced by a Munchener *bier garten*, which announces a band of Tziganes every evening. I never saw the band, nor, indeed, anyone drinking at the rust-covered tables. Possibly, however, it was not the season.

On marketing days the streets are impassable with lumbering country carts, drawn by teams of three or four black buffaloes. Crashing into the pits and gullies which everywhere traverse the roads, creaking, straining, bumping, one pities any mortal condemned to pass an hour in such an abomination. Yet sick and dying men, severely wounded from the front, typhus cases from the epidemic are conveyed in them for days at a time. Sheltered only by the arched roof of plaited wicker, protected from the snow and rain only by their service greatcoats, their sufferings must be appalling, yet one rarely hears a murmur. Lusty peasants and bent old cronies trudge by, curved double with towering piles of firewood or sacks of meal and potatoes. On the sale ground the pandemonium is indescribable. Albanians exhibiting untrained colts, or vicious mules; goats braying, ducks, geese, hens, and oxen each providing their own particular clamour. Olive-faced gypsies scream the virtues of the burnished copper vessels which they make so well; for, throughout Southern Europe your gypsy is a tinker by profession.

Montenegrins, the men gaunt and untamable as their own mountainside, the women attractive for their gleaming teeth and dark, limpid eyes, stand in chaffering groups, their speech sharply differentiated from the Serb by its more guttural intonation. Their brilliant head kerchiefs and shawls focus for a moment as a spot of colour, but soon one passes on to where a crowd has collected, and, pushing to the fore, sees in the centre a little crouched old man, seated on a stool and playing with quivering fingers on a one-stringed violin. It is the guslá, and one listens, touched, as in a voice full of the rheum of years he sings, or rather chants, a low pathetic song. It is a rambling ditty, in which at every few lines recurs the same refrain, caught up by the listeners and sung almost with abandon. What it may be I know not. Perhaps some tale of King Milosh who comes back in spirit to lead his people to victory, or the lament after the field of Kossovo. Mournful and discursive, it seems, for a moment, the embodiment of the national spirit.

In front of the station (outward and visible sign of progress in a land which never changes) the same weary crowd of soldiers sit day after day waiting for trains which never come. Some are playing with greasy cards, squatting on their haunches or seated in a circle on their packs. Others lean against the wall, munching black bread and taking long draughts of the harsh native wine. Many are stretched full length in the mud, their heads on a bundle, their rifles and accoutrement ready by their sides. They are dirty, bearded, haggard. On their sleeping faces is that look of utter weariness which no hope can cure. For in hope lies an ideal, and for them there can be none. *Chair à canon*, cannon fodder, beaten or victorious it is the same, and ungrudingly, unthinkingly they go forth to lay down the one thing that is theirs. Serbia may, perhaps, be a country to die for; but to live in, no!

G. H. F. G.

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Acidosis and its Treatment.

CLINICAL LECTURE BY E. P. POULTON, M.D.

Gentlemen,—In the last lecture on Acidosis I described the nature and origin of the bodies excreted in acetonuria, particularly β-oxybutyric acid and aceto-acetic acid. These bodies circulate in the blood stream, and as they are acids, the neutrality of the blood would be destroyed, unless some compensatory mechanism was brought into play. The compensatory mechanisms used by the body are three in number. The kidneys excrete acid in increased amounts. Ammonia is produced to neutralise it in the blood, and the CO_2 content of the blood is lowered; this latter is brought about by increasing the ventilation of the lungs, so that the alveolar CO_2 is lowered, and with it the CO_2 of the arterial blood, which is in equilibrium with the alveolar CO_2.

Further, it has been definitely shown by Hasselbalch and Barcroft, independently of one another, that in mild acidosis such as occurs in a normal individual, when fed on a diet containing no carbohydrate, the blood does actually maintain its neutrality undisturbed, thanks to these three mechanisms just mentioned.

The further question arises, whether in the very severe cases of acidosis, such as occur in the last stages of diabetes, these three mechanisms are still sufficient to prevent the alteration of the blood neutrality; because, if these fail owing to the very large amounts of the acid formed, the blood will become acid, and if this is the case we may well imagine that this increased acidity of the blood produces an acid intoxication, and that this is the cause of the symptoms of diabetic coma. You will find that this theory of acid intoxication, as a cause of diabetic coma, is very commonly held in medicine, and further the term is applied to all sorts of other conditions where acetonuria is present. For instance, you will hear of a post-anæsthetic acid intoxication, and of an acid intoxication, as the cause of the symptoms in babies who come into the hospital almost comatose from diarrhœa and vomiting. In fact, acid intoxication is such a widely-used term that it is important to understand exactly what it means. It can only mean disturbance in the neutrality of the blood, *i.e.*, an increased acidity, or to put it more precisely, an increase in the hydrogen ion concentration of the blood. Thus, acid intoxication is entirely different from the term acidosis, for this latter term only means that foreign acids are circulating in the blood, which maintains its neutrality unimpaired.

Again, suppose it was found that the blood remained neutral, even in the last stages of diabetes, and that coma was produced, because the acid bodies were poisonous in themselves. You could not call this condition an acid intoxication; it would be as ridiculous as calling hydrocyanic acid poisoning an acid intoxication, for with hydrocyanic acid the molecule itself is poisonous; it does not kill because it is an acid.

When I began working at this subject, I was under the impression that an acid intoxication would be found to be the cause of diabetic coma. On the face of it, it seems a sufficiently likely hypothesis, when you consider that in the last stage of coma, the CO_2 in the blood is reduced from 40 mm. pressure to less than 8 mm. This tremendous fall in CO_2 pressure, a fall of over 80 per cent., itself argues the likelihood, that the acids accumulate in the blood to such an extent as to overwhelm the neutrality regulating power of the body.

Of course the only way of testing this hypothesis is to prepare what is virtually a specimen of arterial blood from a diabetic, and determine the acidity, or more correctly the hydrogen ion concentration of such a sample.

The specimen of arterial blood is prepared as follows: a sample is withdrawn from a vein, by means of a needle and syringe; it is defibrinated by whipping it vigorously in a beaker with a feather for a few minutes: this process has been found not to affect the hydrogen ion concentration. The sample, *i.e.*, 3 c.c. is then placed in a glass vessel and warmed in a water bath up to body temperature, the atmosphere of the vessel containing CO_2 at the same pressure as the alveolar CO_2 of the patient. By this means the blood is converted into arterial blood, because its temperature is the same, and its CO_2 content is also the same.

I am not going to describe to you the exact way in which the hydrogen ion concentration is measured in this sample of blood. Such measurements have been made directly by means of the hydrogen electrode, but in my work, I availed myself of a property of oxy-hæmoglobin that has been shown, other things being equal, to depend on the hydrogen ion concentration. I determined the dissociation curve of the oxy-hæmoglobin of the blood and calculated the hydrogen ion concentration from this.

Here is a summary of my results: I have investigated six separate cases of diabetic acidosis of varying degrees of severity: in the mildest case there was but little acetonuria, and the alveolar CO_2 was 38·3 mm., *i.e.*, within normal limits. In the worst case, the alveolar CO_2 was 12·1 mm.; the blood was taken eighteen hours before death, and the patient was described as being "fairly sensible." Deep coma started twelve hours later.

In all these six cases of varying severity, the neutrality of the blood remained unimpaired.

In two other cases the patients were examined shortly before death; they were both in deep coma, and, practically speaking, they could not be roused. In both cases, the blood was slightly, but distinctly more acid than normal.

Was this acidity sufficient to account for the coma? On the face of it, certainly not; because several of the first six patients were definitely drowsy, and yet their blood was neutral. However, there is a further consideration. It is now well known that in certain conditions the blood becomes more acid than normal; one of these conditions is muscular exercise, another is dyspnœa in cardio-renal disease. I will take the case of muscular exercise: The exercise consisted in walking from sea-level up a height of 1,000 feet, and the time taken for this performance was 30 minutes. On examination the blood was found to be distinctly more acid, than is the case even in the depth of diabetic coma shortly before death. But this exercise was by no means excessive; walking up at this pace entailed no distress, "it was, in fact, the fastest rate of walking at which respiration could be comfortably performed through the nose, and going slower gave the impression of loitering."

Now no one has suggested, that such a comparatively mild form of exercise could produce an acid intoxication, and yet the blood was more acid than in diabetic coma, which proves, that in diabetic coma there is no acid intoxication. I think we can go a step further, although I have no experimental data to back me up, but I think we can argue from analogy, and say that in post anæsthetic acidosis, and in acidosis due to severe vomiting, the symptoms, likewise, cannot be due to an acid intoxication. In fact in all cases of acetonuria, we must get rid entirely of the conception of acid intoxication, as playing any part in the phenomena observed, since it simply does not exist in these conditions.

I have so far said nothing as to whether aceto-acetic acid and β-oxybutyric acid are in themselves poisonous. Although experimental work on this subject is at present rather inconclusive, I think it is quite likely that this will prove to be the case.

I have spent some time in discussing this question, but it really has an important bearing on the rational treatment of acidosis, and that is why I have done so.

Suppose in diabetic coma the blood really became so abnormally acid, as to cause an intoxication, the obvious method of treatment would be to neutralise the blood as quickly and thoroughly as possible with alkali, and nothing would serve the purpose better than administering a considerable amount of sodium bicarbonate intraveniously. This is, in fact, the stock treatment. The results are most disappointing; in the majority of cases the state of coma remains absolutely unaffected. But after all the result is scarcely surprising since the blood is practically speaking, not acid at all. It is no use trying to neutralise an acid, that still remains in the body and acts as a poison. The correct treatment will be to try and get it excreted, and this will be done best by giving alkali, because the kidney can excrete salts, though its power to excrete acid is limited. However the alkali must be given in plenty of time, and there will be no object in giving it intravenously. The simplest plan is just to give it by the mouth.

I will admit that in a minority of cases you find a remarkable change resulting from an intravenous injection of sodium bicarbonate; the patients wake up from their coma and are able to talk to their friends. They subsequently relapse into coma. I think the real reason of this change is that in coma the blood pressure is very low indeed, and if you inject intravenously any fluid, whether it be sodium bicarbonate or normal saline, there will follow a temporary rise in blood pressure, which will increase the cerebral circulation, and cause the patient to regain consciousness.

Before considering the treatment of acidosis, it would be as well to indicate the methods that are commonly used to estimate its severity, and to foretell the onset of coma. For the most part the methods follow directly from the phenomena of acidosis mentioned in the last lecture.

First of all, what are the clinical signs and symptoms of the onset of coma? The early symptoms are malaise, langour and weakness, followed by drowsiness. On the other hand, there may first of all be restlessness and delirium. Other early symptoms are pain and tenderness in the epigastrium, and this may be be accompanied by vomiting. Very often the patient is constipated; the importance of this

was mentioned last time. In the later stages the pulse becomes rapid and weak, the blood pressure falls, the tension of the eyeballs is diminished. The urine may show a sudden fall in the volume excreted, as quite an early sign, and this is associated with a fall in the output of sugar and often in the output of acetone bodies, which is presumably due to to their retention in the body. There is slight albuminuria, possibly due to poisonous action of the acetone bodies on the kidneys. The most important sign of all is the air-hunger; the respiration is deeper than normal, though its rate may be slower or quicker or it may remain the same.

These signs and symptoms are often a very poor guide to the state of acidosis, as I have found out on many occasions, and there are other more valuable methods of clinical investigation.

First and foremost the alveolar CO_2; this appears to be an absolutely infallible guide. There is a clinical instrument of Fredericia's, that I will not describe now as it has been dealt with fully elsewhere;* and this instrument admits of the determination being carried out within ten minutes; the advantage of it is that it makes the whole determination as simple as an ordinary urea estimation in urine, by the hypobromite method, and the result gives you a measure of the amount of acids circulating in the blood at the moment. Thus a value of 2 per cent. means that coma may supervene within twenty-four hours. A value of 3 per cent. or 4 per cent. is less dangerous, in the worst event coma will not come on for two or three days, and patients may live at this level for a long time. If a value of 5 per cent. is obtained there is no danger at all. By means of this instrument you can readily divide your acidosis cases into two groups; (1) the mild cases where the CO_2 falls within normal limits, and (2) the severe cases where the alveolar CO_2 is definitely lower than normal; in this group the patients are always in a condition of more or less unstable equilibrium, and the greatest care must be taken to prevent the onset of coma.

Another clinical method is the determination of the output of ammonia in the day's urine. The normal output is less than 1 gram.; values of 2, 3, or 4 grammes indicate danger. Suppose that a patient is being seen for the first time, a twenty-four hour's specimen of urine will probably not have been collected; in this case you can make use of the ammonia index. A specimen of urine is obtained, the percentage of ammonia nitrogen is estimated by the simple method of "formol titration." The urea percentage is also determined, half this value will give you approximately the percentage of total nitrogen in the specimen, because 100 gms. of urea contain 47 grms. of urea nitrogen, and usually the urea nitrogen is 94 per cent. of the total nitrogen of the urine as determined by Kjeldahl's method. The ratio of the ammonia nitrogen to the total nitrogen thus obtained is the ammonia index. This is usually 3 or 4 per cent. Values of over 10 per cent. indicate danger.

All these methods may be of value, but I want to impress upon you that the alveolar CO_2 method is the most valuable of all; it is absolutely infallible provided it has been correctly carried out.

Here are some instances to show this: A woman, aged 42, was admitted with diabetes into Miriam. She had neuritis in the legs, which were painful and wasted. The ferric chloride reaction was marked. The ammonia index was 14 per cent. She was drowsy and had a headache. Clinically, it was considered that coma was imminent. However, the alveolar CO_2 was 4·8, *i.e.*, practically normal, and the best prognosis was given. Two months later the same woman, while in hospital, suddenly began to vomit, bringing up bile-stained fluid. She had abdominal pain, acetone was smelt in the breath. The urine contained albumin, and much aceto-acetic acid: the ammonia nitrogen was 1·2 grms. per diem, and the index 13 per cent. The case was looked upon as hopeless. However, the alveolar CO_2 was 3·7 per cent.; a good prognosis was given, and she recovered from her temporary indisposition next day, and was discharged a month later feeling much better for her stay in hospital.

Here is another instance of an opposite kind, because here the ammonia determinations gave the impression that the patient was in a much less dangerous condition than she really was.

Date.	Alv. CO_2 %	Ammonia Nitrogen.	Index.
March 11th	—	0·29 gms.	6·4 %
March 12th	2·7	—	—
March 13th	Coma began	0·34 gms.	10 %

It is true that the ammonia index was a little high on March 11th, but the ammonia nitrogen was extremely low; this was partly because she was excreting very little urine, and she was also having large doses of sodium bicarbonate, which would also diminish the ammonia output, and thus help to disguise the true state of affairs.

* *British Medical Journal*, Sept. 11th, 1915.

The value of 2·7 per cent. CO_2 on March 12th showed the severity of the case, and coma began sometime during the next day.

These examples will serve to indicate the extreme value of an alveolar CO_2 determination, as a guide to prognosis and treatment.

The object of treatment in diabetes is, broadly speaking, to diminish the output of sugar in the urine. This is accomplished by cutting off carbohydrates from the food. There are advantages in doing this, quite apart from the question as to whether you can get rid of the sugar altogether, which is often impossible. A person who is passing three or four litres of urine a day, containing a high percentage of sugar, is not in a happy condition. He is continually thirsty, his mouth is dry, and he often suffers from skin eruptions, especially round the urethral orifice. However much he eats, he does not put on weight. If you can diminish the output of sugar, the urine becomes less, his thirst diminishes and he puts on weight, as there is no longer a continual drain of fluid from the tissues. Generally, he feels in much better condition.

On the other hand, you have to remember that your treatment, though it may be beneficial to the patient in these respects, has the great disadvantage of increasing the acidosis. In the case of healthy individuals, if you cut off all carbohydrate food, small quantities of aceto-acetic acid, and β-oxybutyric acid will still be passed. Further, the acidosis produced by this treatment in diabetes will often be much greater than in a healthy individual.

The diminution in the output of sugar, and the prevention of acidosis are processes often incompatible with one another. The great danger is that of being so energetic in diminishing the sugar output, that the patient is sent into coma from the acidosis. This is a very important question, because it is stated that the commonest cause of coma in diabetes is the doctor's treatment. So if you are going to treat a patient on a rigid diabetic diet, you will have to be very careful about the acidosis.

As I have already mentioned, there are roughly two clinical groups of patients with acidosis In the first group, which comprises the mild cases, the effect of a rigid diet is to cause a slight temporary increase in the acidosis (the alveolar CO_2 is hardly lowered at all), which to a large extent disappears on continuing the diet. There will be no danger in keeping such a patient on a rigid diet for a long time continuously, and if you can keep such a patient sugar-free, you may be able to introduce gradually carbohydrate into his diet, which will be metabolised and not excreted as sugar.

The second clinical group comprises the severer types of acidosis, though the sugar output may be no more in this group than in the last one. However, the alveolar CO_2 is definitely lowered, and any treatment with a rigid diet must be carried out with great caution. I believe you cannot be certain of the effects of your treatment unless you take a measurement of the alveolar CO_2 at regular intervals, in conjunction with your examination of the urine. These are the types of case which are best treated in an institution, where there are facilities for doing the requisite examinations. Unless you are prepared to pay all this attention to the acidosis, you had much better not attempt any rigid treatment at all. What you should do instead, is to limit the intake of carbohydrate to one, two, or three ounces a day, by allowing a certain amount of milk, potatoes, oatmeal or bread, etc. Your object will be to get rid of the polyuria and the excessive thirst as far as possible, but not to try to get rid of the sugar altogether. Many cases will get on very well with such treatment. Of course in prescribing any diet for a long period you will pay particular attention to the body weight

There are certain other points that I should like to mention in this routine treatment of a case. It has been found that excessive amounts of various metallic bases are excreted in the urine. These are required to neutralise the aceto-acetic and β-oxybutyric acids, which are thus excreted as salts. The bases concerned are Na_2O, K_2O, CaO, and MgO, It has even been suggested that this drain from the tissues is the cause of diabetic coma, because presumably an amount of these substances, sufficient to compensate for the loss, is not obtained from the food. Whether this is so I cannot say, but in any case it will be a good plan to give small doses regularly, to obviate any possible danger in this connection.

Here is a possible formula :—

℞ Sod. Citrate gr. xxx.
Pot. Cit. gr. xx.
Calc. Carb. gr. ii.
Mag. Carb. gr. ii.
Aq. Chloroformi ad ℥i. t.d.s.

Again I would urge on you the importance of preventing constipation.

It is also inadvisable to put a severe diabetic to bed. They seem to do much better walking about. Of course it is quite another matter if

any special treatment is being adopted for the time being, such as semi-starvation. In this case, it would be the natural thing to keep the patient quiet in bed.

So much for the routine treatment of a severe case of diabetes. However, if you come across a case that you have reason to believe is on the verge of coma, you will have to use more energetic measures.

There are two fundamental principles in such treatment. The first is to arrest the production of acetone bodies in the organisms, and the second is to promote their elimination.

The first of these is accomplished by dieting, and it is remarkable that the result may be obtained by two very different methods of treatment. The first is the safest to adopt in an obviously bad case, and it is the obvious one, viz., to relax the diet completely and let the patient eat large amounts of carbohydrate. In cases of great emergency a 6 per cent. solution of dextrose or levulose may be given subcutaneously, or as an enema.

The other method is to starve the patient completely, or what Dr. Graham has shown to amount to very much the same thing, to give the patient a diet consisting of fat with a comparatively small quantity of protein and of insufficient calorie value. Such a diet is known as a "vegetable day." It may consist of lettuce 2 ozs., greens 10 ozs., butter 3½ ozs., 5 eggs, 1 pint of veal broth or beef-tea, coffee, tea, water. lemonade ad lib. It is remarkable how with such a diet, a patient's acidosis will diminish, as shown by a rise in his alveolar CO_2, and at the same time the sugar output will fall. I cannot explain the reason of it; it is the reverse of what you would expect. It is found, that patients often do better, if they are given one or two vegetable days, followed by a diet containing plenty of carbohydrate. This carbohydrate may be given in the form of oatmeal, when it is called "Von Noorden's Oatmeal Cure," or you can give large quantities of potatoes. Here are the quantities suitable for a "potato day":—potatoes 20 ozs., butter 7 ozs., 5 eggs, coffee, tea, water, lemonade, *ad lib.*

It is found that, if a certain amount of carbohydrate is given in the form of oatmeal, or potatoes, you have a smaller output of sugar, than if similar amounts of pure starch are given. Why this is so, I do not know; it has nothing to do with the particular starch in oatmeal or potato, because if this starch is prepared in the pure state, it has exactly the same effect as pure starch, and a less favourable effect than the oatmeal and potato prepared as usual.

The normal method of treatment along these lines is to give two or three vegetable days running, and then two potato days, or oatmeal days, followed by another series of vegetable days. The results are often remarkable. The sugar diminishes, the acidosis gets less, and the patient puts on weight.

The second fundamental principle is that of eliminating the acids. This line of treatment is excellent in an emergency, when there is already an excess of these acids circulating in the blood; but it is better to keep it for an emergency, because it is obvious that if a case of diabetes is being treated over a prolonged period, it will be much better to try and arrest the formation of the acids, as already described, than to allow them to accumulate, and only look after their excretion. The treatment will be of particular value in conditions of acetonuria, other than diabetes, such as post-anæsthetic acidosis, or cyclical vomiting; because if you can once eliminate the acids, there will not be much danger of their being re-formed, as these conditions are always quite acute.

The best method is to administer sodium bicarbonate, or in some cases sodium citrate. I have pointed out, that there is no particular object in giving the salt intravenously. It is best given by the mouth, but in an emergency ordinary British Pharmacopeial doses are useless. It is possible to give as much as three ounces sodium bicarbonate in the day. Another good way is to give it subcutaneously, but this must only be done if care has been taken to neutralise the solution by passing CO_2 through it, after it has been sterilised; because the process of sterilising the salt drives off CO_2 and partially converts it into the normal sodium salt, which is alkaline. If you do not neutralise it you may cause gangrene.

Finally I will quote a case, illustrating these two methods of treatment. The patient is in Miriam 23 at the present time. When I saw her first, she was definitely drowsy, her breath smelt sweet, and the alveolar CO_2 was 2·6 per cent. The treatment adopted was to keep her in bed and allow her one pint of milk in the twenty-four hours, which contained 20 grms. of dextrose (*i.e.*, about two-thirds of an ounce), and the calorie value was 390. This was virtual starvation, with a small allowance of sugar. At the same time we gave her two litres of a specially neutralised 2 per cent. solution of sodium bicarbonate subcutaneously. Twenty hours later the alveolar CO_2 had risen to 4·3 per cent., *i.e.*, almost the normal value; all the drowsiness had disappeared, and now—

six weeks after this treatment—she feels perfectly fit, and the acidosis has practically disappeared, though she is still passing a lot of sugar. The case illustrates what can be accomplished by energetic treatment of a diabetic on the verge of coma.

Nursing News.

British Expeditionary Force,
14th September, 1915.

"We had an excellent crossing from Folkestone, and were met at Boulogne by a very nice Matron, who saw to everything for us, so that we had no trouble with our luggage at all.

"Some well-meaning Tommies packed us into Red Cross Ambulances, resembling church pews, and we sat face to face, our knees touching, and our hold-alls blocking what little view we might have had. We were motored up to an hotel, where we had a very acceptable lunch. After lunch we received our directions, and were divided up into our different parties. Seven of our Guy's party left in the evening for No. 13 and Sister MacManus for No. 18, when Nurses Gladstone, Richardson, and myself were told that we were to spend the night in Boulogne and journey to our destination the next day.

"We spent the evening exploring the town, which we thought quaint, but very dirty. At 2 p.m. the next day we started on our journey in a very hot and stuffy train such as the natives of France love.

"We had comfortable seats in the first-class, and, being English, were well provided with food. At 8 p.m. we reached ——, where we were told to change. The small café was stormed by the stronger sex, but we managed to procure a bottle of wine with the help of a Tommy, and sat down to picnic on the station. Just as we were about to start on our sandwiches, chocolate, fruit, and wine, the train for —— dashed in. There was a very hurried mixing of all ingredients, which we managed to separate when once more in the train. At midnight we reached ——, and were motored up to No. 10 General.

"*It was an impressive scene when we arrived*—the stretch of white tents in the moonlight and the sentries keeping guard all round. The night sisters gave us some tea, which was very acceptable, as the night was very cold. Afterwards we were given two blankets each, and spent our first night on the floor of an empty tent.

"At 6.30 a.m. we were roused by one of the Sisters and presented with one small tin basin to wash in. Our luggage having been locked up in a far tent, we were devoid of soap, flannel, and towel. However, a passing Sister supplied us with soap.

"We all felt very shy and new as we made our first appearance. Our first day was spent in fixing up our tents and arranging our furniture. On the following day we were each put as Sister-in-Charge of a surgical tent with 26 beds. Mine was the only one of the three that boasted any patients at all, and they were three convalescents who departed two days after my arrival.

"Our means for boiling and sterilising are very *rustic, having only a small methylated stove* which goes out every five minutes with the draught. Our cupboards are made out of old packing cases and soap boxes and our dressings are kept in sweet or pickle jars. We are allowed two hot-water bottles and two washing basins, one being kept for the medical officer.

"What one misses more than anything is having no other trained nurse in the ward, especially when there are bad cases. The junior orderlies who work with us have had no training at all, most of them having been sent down from the trenches for some defect. They are very useful for cleaning purposes, but hopeless for nursing. My junior orderly is 52, and has been sent down for lung trouble. If I want him to help with a patient he disappears in terror. He is a road-mender by trade at Aldershot Barracks.

"This letter sounds as if we had already started to grumble, but we are really very happy here. It is a most beautiful spot, two miles from the town and some very lovely pine woods."

Palace Hospital, near Alexandria,
16th September, 1915.

Dear Matron,

I have been here a fortnight to-day and am now beginning to feel settled, at least, I have felt pretty much at home here ever since I arrived; it is all so absurdly like India and Indian life, and what is not India in the hospital, is like the Navy.

It is a perfectly beautiful place, the late Khedive's summer palace. We (the Medical Officer and Sisters, 25 of us) live in the Khedive's own quarters. His various harems and his relations' houses are turned into hospitals. There are 500 beds at present, but I believe we are to increase to 1,000. They say the Khedive, who is at present in Austria, is exceedingly wrathful at the desecration of his favourite dwelling place, and has appealed to the "crowned head of Europe" to interfere. In the meantime it makes a simply ideal place for the men.

The sea seems to surround us, the most perfectly blue sea imaginable, and there are trees of every description, many of them flowering, right up to the water's edge.

This is supposed to be a convalescent home, but we get a good many serious cases, not surgical so much as medical. There is so much dysentery; out of the last batch from the Peninsula, last week, of 800 there were only 40 wounded.

We have half Australians and half British. The Australians' keenness to go back is simply amazing. Their one idea is to get back to their "pals" who are still "going through it." When you hear what they have gone through on the Peninsula their spirit is simply beyond words. There are some boys of 17 years, and it makes my heart ache to think of their going back. The men who are fit, bathe and boat and fish, or wander about all day. They are burned nearly copper colour, and as they all wear shorts (very short) and every imaginable colour of shirt, they are a picturesque crowd.

The sisters work very hard; they start at 7.30 and are off at 8 p.m., but have three hours every day and a half-day a week. There is one Sister and one V.A.D. and two orderlies to each ward. The largest ward has 175 beds. Then there is the big "dressing-room" in charge of two Sisters, as all the dressings of the men who can walk from the large block of 330 beds are done there. They are kept busy all day long. At night a Sister and an orderly are on duty in each block, as the wards are so far apart.

The hospital had been opened nearly three weeks when I came, but they had left all the distribution of the Sisters, off-duty times, etc., for me to arrange. Also there was absolutely no arrangement regarding diet sheets, bed returns, etc. I had to start those, more or less on Guy's lines, of course. The fact of sending printed forms regularly to the "office" each day seems to have worked wonders! I do not know what Sir Cooper would do about an I.O.D. book!

We have men in in such big numbers and then all sorts and degrees of mysterious stages of transfer and discharge and also we are continually "putting up" extra beds, so our bed returns are really a problem. We are sometimes reduced to walking round and *counting* each bed.!

There is a lady house-keeper, a very charming woman who has lived in Egypt for years, who has offered her services and has taken charge of all the servants, laundry (done by the Jewish refugees on the roofs of the houses), stores, etc., which is an enormous relief, of course, as I cannot speak a word of Arabic or Yiddish.

I look after the diets and interview a wonderful person with extremely grand manners who does all the catering. He promises each day to do everything I ask, and really never does anything. The Chief is French and he also appears at the interview, which is carried on in a mixture of English, French, and the few Arabic words I have managed to pick up.

Feeding is a great problem, as there are practically no fresh vegetables to be had, and so many of the men cannot eat meat, and the fish, eggs, and milk are poor in the extreme. The bread is always sour, and the Chief simply cannot or will not make tea, which the Australians do not seem able to live without.

We get a great many visitors, as the place is so beautiful, and it is just a nice motor ride from Alexandria. The other day a Guy's man turned up (R.A.M.C.) and greeted me as "Sister Lorna," and reminded me that a very little while ago I had taken a ward maid to him in the surgery with a septic finger. His name is Champion.

We have a chaplain at present. I hope he will stay, but he is only convalescing and is anxious to get back to his brigade at Gallipoli. I have been helping him fix up a chapel in the largest block, and we have two celebrations a week and a fair number of the men come.

I am afraid you will be tired of all this. I think I must be doing "war work" under very pleasant conditions; as a matter of fact, our quarters, etc., are sheer luxury in these days.

Yours sincerely,

LORNA WOOD.

Miss E. V. Lulham (Sister Violet) left England on Thursday, October 6th, to go out to Alexandria under the Q.A.I.M.N.S.R., and Nurses Brennand, Owen, S. Gibson, and Sawyer left the same day for France.

Notes on Two Cases of "Cresol" Poisoning.

Case I.—J. C., male, aged $2\frac{8}{12}$ was admitted into Mary under Dr Shaw on 9th August, 1915, with a history of having swallowed about a teaspoonful of "Oil of Tar." The first effect seems to have been a violent convulsion and then nausea and retching without any vomiting.

On admission, patient appeared very flushed and his skin was very dry. Emetics were administered in the surgery and the patient vomited well. Both vomit and patient's breath smelt strongly of creosote.

On auscultation there was much bronchitis. Pulse 128; temperature 98°; respiration 36.

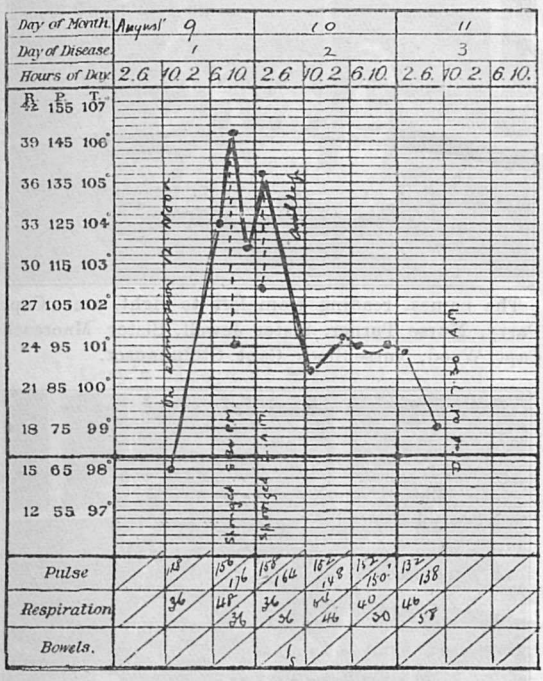
On admission to ward patient was given atropine hypodermically ($\frac{1}{200}$ gr.) but as the bronchitis increased during the afternoon atropine gr. $\frac{1}{150}$ was given two hourly. During this period the temperature commenced to rise until at 8.30 p.m. it reached 106°. This was reduced immediately to 101° by tepid sponging, but at 10 p m. had risen to 103°.

The bronchitis also increased and the atropine was changed from $\frac{1}{150}$ 2 hourly to $\frac{1}{200}$ 3 hourly, and linium ipecacuanha was given as an emetic. This measure continued with frequent sponging to bring down the temperature had the desired effect, and at 6 a.m. (10th August) patient was reported as sleeping quietly. No doubt the steam kettle which was kept going continuously by patient's bed helped to attain this condition.

During the whole of the 10th August patient seemed as though recovering, although the temperature still

remained about 100°, but at 6 a.m. on the 11th the temperature dropped to 99°, but at 7.30 patient appeared to have a sudden attack of respiratory obstruction and died before any attempt at intubation or tracheotomy could be made.

At the post-mortem examination it was found that no corrosive at all had entered the stomach. The œsophagus was reddened throughout the whole of its length, but especially at its upper and lower thirds. The trachea was very red, and the larynx slightly œdematous and red, and there were multiple areas of collapse in the lungs. Heart and liver were normal. The bladder mucous-membrane was congested.



Case II.—A. H., female, aged 24, brought herself up to the surgery on the 16th September, 1915. With her she brought a 6 oz. bottle containing a brown viscid liquid which smelt of carbolic. It was neutral to litmus, had a soapy feeling, formed an emulsion with water, and irritated the fingers when applied thereto.

Patient stated that she had drunk about a table spoonful of this mixture with suicidal intent.

When seen in surgery she was a little drowsy and complained of general pains. Her mouth was sore and in places the mucous-membrane was browned. Emetics were administered with good results and patient was admitted into Mary under Dr. Hertz.

There were no abnormal physical signs. Pulse and temperature remained about normal all through illness.

Patient made a good recovery and was discharged in care of relatives.

D. H. A. GALBRAITH.

A Case of Laryngeal Diphtheria ending in Death from Heart Failure.

J. C., male, aged 3, was admitted into Isolation under Dr. Fawcett on 17th September, 1915. For three days he had complained of a sore throat, which on morning of admission to ward had got worse, and was further complicated by marked difficulty in inspiration.

On admission at 9.30 a.m., pulse 124, temperature 100°, respiration 24. Patient was "sucking in" violently, but he did not seem in any mental distress. There was a patch of diphtheritic membrane on left tonsil. The lungs were normal, except for a patch of bronchial breathing at the angle of the left scapula.

6,000 units of anti-diphtheritic serum were given, and a swab from fauces was examined bacteriologically with a positive result. Tracheotomy was performed at 5.30 p.m. and patient showed immediate signs of relief. The steam kettle was kept going continuously, and patient's fauces were painted with a carbolic and tannic acid paint t.d.s. Patient slept well during the night.

The next morning another 6,000 units of anti-diphtheritic serum were given and the day passed without any untoward symptoms appearing, and during the night the patient again slept well. At 9.45 a.m., when the inner tube was out and being cleaned, patient appeared to choke, and in spite of being tied down in bed managed to sit up and then collapsed suddenly. His pulse became very weak, and injections of strychnine and ether with application of hot towels to chest proved useless and patient died.

At the post-mortem there were two large patches of membrane in the trachea, one above the tracheotomy wound and the other below, but not in a position to obstruct the entrance to the tube. No other abnormalities were found, and death was attributed to heart failure. It should be noted that there was no surgical emphysema or pneumo-thorax tending to complicate the tracheotomy.

D. H. A. GALBRAITH.

Appointments.

Naval.

Staff-Surgeon C. G. Sprague to the *Pembroke* additional.

The undermentioned have been granted commissions as Surgeons for temporary service:—F. C. Newman, H. F. Percival.

Royal Army Medical Corps.

Major C. H. Fagge, 2nd London (City of London) General Hospital, to be temporary Honorary Lieutenant-Colonel, and to remain seconded whilst serving with the Hampstead Military Hospital.

H. L. Eason has been appointed temporary Lieutenant-Colonel.

The undermentioned Lieutenants to be temporary Captains:—F. A. Osborn, H. C. Lucy, H. G. D. Eccles.

To be temporary Lieutenants:—M. M. Adams, J. Young, R. D. Smedley, E. Huntley, P. C. Litchfield.

George F. Charles, L.D.S., has been appointed Dental Surgeon "somewhere in France," with a commission as Lieutenant. Letters to be addressed as usual to the Turret, Sea Road, Bexhill-on-Sea.

London Field Ambulance: — The undermentioned Lieutenants to be Captains—L. P. Harris, G. B. Pritchard, Major H. M. S. Turner (Falkland Islands Volunteer Corps), temporary, P. S. Price.

North Midland Field Ambulance: — Lieut. G. F. Haycraft to be Captain.

West Riding Field Ambulance:—Lieut. H. Lee to be Captain.

East Lancashire Field Ambulance:—Lieutenants F. Hodgson and H. E. Fox to be Captains.

Wessex Field Ambulance:—Captains R. Eager and W. T. P. Meade-King to be temporary Majors.

Welsh Field Ambulance:—Lieut. H. N. Collier to be Captain.

London Casualty Clearing Station:—Lieut. E. S. Taylor to be Captain.

Capt. G. F. Mullally, R.A.M.C., to be Surgical Specialist to No. 8 Casualty Clearing Station, B.E.F.

Attached to other than Medical Units:—Lieutenants G. H. H. Manfield and J. Walker to be Captains.

Change of Address.

Capt. A. S. Liebson, Borden Camp, Martinique Barracks, Hants.

Lieut. T. E. A. Carr, from Station Hospital, Malappuran, S. India, to 2/1st North Midland Field Ambulance, Watford, England.

W. Rendle, from Hempton Lodge, Hythe, to The Limes, Kemble, near Cirencester.

R. A. Chisolm, M.D., 85, Prince of Wales' Mansions, Battersea Park, S.W.

George F. Charles, L.D.S., has been appointed Dental Surgeon "somewhere in France," with a commission as Lieutenant. Letters to be addressed to "The Turret," Sea Road, Bexhill-on-Sea.

Lieut. V. Drew, British Field Hospital, IIme. Armée, Mladenovats, Serbia.

Home Address—H. C. Cameron, M.D., F.R.C.P., 2, St. Katherine's Precincts, Regent's Park, N.W.

E. Deane, Balmoral, St. Aubins, Jersey, C.I.

Allan H. Todd, M.B., B.S., B.Sc., F.R.C.S., M.S., 6, St. Thomas's Street, London Bridge, S.E.

G. T. Foster-Smith, M.B., B.S., 58, Underhill Road, East Dulwich, London, S.E.

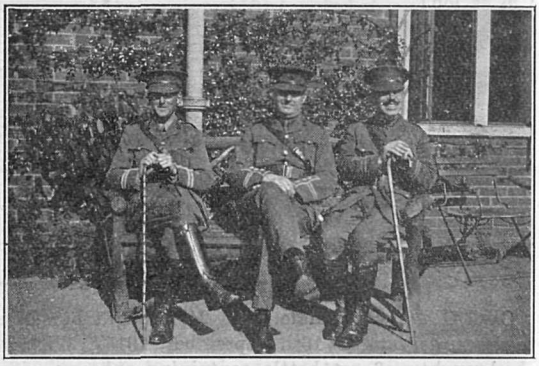
Correspondence.

To the Editor of Guy's Hospital Gazette.

2nd Eastern General Hospital, Brighton.

Dear Sir,—Enclosed are photos of the Guy's doctors and nurses now working at the Dyke Road branch of the 2nd Eastern General Hospital, Brighton, and I wondered if they would be any use to you for publication in the Guy's Gazette.

The names, reading from left to right, are: Capt. Parry, Nurse Turner, Sister Jewell, Sister Macreath, Capt. Wood, Nurse Slack, Capt. Steinhauser.



Capt. Parry, Capt. Wood, Capt. Steinhauser.

The three Captains belong to the R.A.M.C. Territorial Force. Capt. Wood is dentist for the hospital, Capt. Parry is a general surgeon, and Capt. Steinhauser is resident as house-surgeon. The Hospital, in time of peace, is a Boys' Grammar School, and has adapted itself well as a hospital.

We are at present very slack, and the Hospital nearly devoid of patients, but as we are told that is as an "efficient base hospital" should be, we are trying to realize with Milton that "They also serve who only stand and wait." Our sympathies go out to our Navy.

—Yours truly, LUCY E. TURNER.

The Convent of the Sacret Heart,
Brighton. Sept. 23rd, 1915.

Sir,—I noticed in your Students' number last week under the rubric of the "Debating Society," the following astonishing sentence: *An endeavour has been made to choose subjects within the scope of the limited interests of the medical student.* Truly a remarkable confession. As an occasional, and a rather bored attender at debates, I would like to suggest that the annual failure of the Society to produce anything but the usual discursive conversation is largely due to this assumption that the medical student is a being specialised for the absorption of certain facts, but utterly ignorant of issues at large. Surely it is high time one realised that the medical man stands or falls largely on his qualities as a man who can be all things to all men. The mere student, the professorial manner is well enough in the abstract sciences, but medicine pre-eminently calls for men of the widest sympathies and culture. From the point of view of practice, our six months of embryology could well be substituted by a course of demonstrations in the bedside manner. Let us have no more, then, of this pernicious nonsense.—Yours, etc.

"DIALECTIC."

Notices.

Guy's Hospital Medical School.

At a meeting of the Court of Committees held on Friday last, the following appointments were made:—

Sir William Dunn Lecturer on Pathology.—Dr. P. P. Laidlaw.

Gordon Lecturer on Clinical Chemistry.—Mr. J. H. Ryffel.

The following appointments have been made for one year from October 1st, 1915:—

Resident Surgical Officer.—Mr. W. E. Tanner.

Dental Anæsthetist.—Mr. A. M. Zamora.

Anæsthetist to Bright Ward.—Mr. A. H. Todd.

October 4th, 1915.

The following Entrance Scholarships have been awarded:—

Senior Science Scholarships for University Students.—£75 Charles Walter Wylde Armstrong, St. John's College, Oxford; £35 Harold George Burford, Christ Church, Oxford.

Junior Science Scholarships.—£120 Edward Henry Roche, Preliminary Science Class, Guy's Hospital; Certificate, Reginald Cyril Bell Ledlie, Preliminary Science Class, Guy's Hospital.

Scholarships in Arts.—£100, Harold John Selby, Cheltenham College; £50, Kenneth Herbert Hugh-Jones, Bradfield College, Berkshire.

29th September, 1915.

Metropolitan Asylums Board.

INSTRUCTION IN FEVERS.

A Course of Instruction (Two Months) in the Diagnosis and Treatment of Fevers will be held during November and December, 1915, at the South-Eastern Hospital, Avonley Road, New Cross, S.E., by F. M. Turner, M.D., Medical Superintendent, on Tuesdays and Fridays, at 11 a.m., beginning on Tuesday, 2nd November.

Students who desire to attend this course of Instruction must, *before* attending at the Hospital, bring, between 11 a.m. and 4 p.m. on any week-day (*except Saturday*), or send by post, to "The Clerk to the Metropolitan Asylums Board," Victoria Embankment, E.C.:—1. Authority from the Dean of the Medical School. 2. Fee—£3 3s. 0d. for two months' course. (Cheques to be made payable to "The Metropolitan Asylums Board). 3. Full Name and Address, and name of Medical School. (N.B.—The name must be in Full, and must be Distinctly Written.)

Note.—It must be distinctly understood that no certificate will be granted to any Student who has attended for less than two days in each week during the whole period of two months.—By order,

T. DUNCOMBE MANN,
Clerk to the Board.

August, 1915.

Mrs. PYE-SMITH,
26, Hyde Park Square, W.

Would be very grateful for help for The Comforts Fund, of her son's Battalion, 11th The King's (Liverpool Regt.) Pioneers.

LIST.

Shirts.	Tobacco.
Socks.	Note Paper.
Vests.	Pencils.
Pants.	Mitts.
Mufflers.	Acid Drops, in tins.
Helmets.	Felt Slippers.
Handkerchiefs.	Pocket Knives.
Soap.	Knitted Waistcoats.
Cigarettes.	

Or Money to buy these.

Reviews, etc.

The Operations of Surgery (Jacobson), 6th Edit., by R. P. Rowlands, M.S. Lond., F.R.C.S. Eng., Surgeon to Guy's Hospital, Lecturer on Anatomy to the Medical School; and Phillip Turner, B.Sc., M.S. Lond., F.R.C.S. Eng., Surgeon to Guy's Hospital, Teacher of Operative Surgery to the Medical School. With 797 illustrations (40 in colour), vol. i. pp. 1030; vol. ii. pp. 934. (London: Messrs. J. & A. Churchill, 1915.) Price, £2 10s.

In the preface to the sixth edition the authors pay a just tribute to the work of Mr. Jacobson. The five previous editions were mainly from his hand, and they feel that they owe much to the man who laid the foundations of the structure so truly. The same sense of regret will be with many Guy's men on learning that Mr. Jacobson has been unable to continue his authorship.

Guy's has been ever proud of this work which stands for all time as a monument to one of her most distinguished sons.

Mr. Rowlands and Mr. Turner must be congratulated on keeping up the general excellence of the work. They have, wisely, realised that it was better not to interfere with the general plan of the two volumes. The arrangement of placing all the abdominal surgery in the second volume is most satisfactory. The authors state in their preface, "Time and space set a limit to the operations which can be described. Therefore, preference is given to those we have found most useful." There is a particularly "Guy's touch" about this observation, which will appeal to men who pride themselves on the practical teaching of their old Hospital.

The chapters devoted to "the examination, preparation, and after-treatment of the patient" are delightful reading, and we regret that the authors have found it impossible to enlarge this portion of the work. We feel sure that cases illustrating the various points brought out would be most acceptable and increase the interest as bringing in more the personal element. This is so characteristic of other parts of the work that we regret it is omitted in these chapters.

At the present time, when young surgeons find themselves forced to perform major operations, it must be most comforting to feel that it is possible to fall back on such a book as this where all difficulties are explained and all pit-falls exposed.

These new volumes come out at a time most opportune, as there is no doubt that more and more is being asked of the younger men, and they would be well advised to make it their business to have "Rowlands and Turner" at their fingers' ends.

The authors have carefully revised the whole work, and in many instances have found it necessary to rewrite large portions. In keeping up-to-date such a book as this, the rapid progress of surgery makes revision unavoidable However, the present writers have been particularly fortunate in their choice, and have been very jealous to keep always well in view the claim that their work is one for the practical man.

Perhaps the reason that more space is not devoted to the operative treatment of fractures is that it now comes under a special heading and is hardly an operation which a general surgeon can safely perform. As, however, it is an operation particularly associated with the hospital, it seems a pity that more space cannot be devoted to the open method. The illustrations showing the open method of fixation in oblique fracture of the tibia are hardly just to the originator of the operation, as the steel plate employed is too small and is put on the subcutaneous surface of the tibia. This error is very common in the published American criticisms of the method, and we are surprised to find the same mistake in a Guy's work.

The illustrations are numerous and are generally very clear. Colours have been employed in some of the anatomical drawings and make for clearness of detail.

There is one very characteristic trait in this work which the present authors have been fortunate enough to adopt and bring up to date. It is that on reading accounts of various operations one is constantly reminded by various, almost imperceptible asides of the writer that he is living in his work and meeting the difficulties he describes from day to day. So many works on Surgery discuss the Art in such a matter-of-fact and uninteresting style, that a page of Bradshaw can well compare with them for variety of expression. This is true of many surgical exposures from across the water where it is found necessary to replace the want of English by a lavish expenditure on unnecessary illustrations. The charm of this work lies in the fact that it is in the text rather than in the illustrations that the value lies.

The book will appeal first of all to Guy's men because it will remind them constantly of their old work in the hospital, and the quotation of one case will at once call up to mind scores of others seen under various circumstances. There is no work quite like "Jacobson" to a Guy's man, and no work which will repay him quite so much for careful reading.

To the wider public—we can truly say the "world-wide public" as regards this book—we recommend the two volumes as being the first work on operative surgery in England. It will be to the public advantage when this is generally recognised.

Additional List of Guy's Men on Active Service.

MILITARY.

ANDREW, Captain G. W. M., R.A.M.C.(T.)... ...	North Midland Casualty Clearing Station, B.E.F.
BIRKS, Lieutenant A. H., R.A.M.C.	43rd Field Ambulance, 14th Division, B.E.F.
CHANING-PEARCE, Lieutenant W. T., R.A.M.C. ...	11th Field Ambulance, B.E.F.
COSTOBADIE, Captain V. A. P., R.A.M.C.(T.) ...	North Midland Casualty Clearing Station, B.E.F.
CRAWFORD, Lieutenant —, R.A.M.C.	37th Field Ambulance, 12th Division, B.E.F.
DAVIS, Lieutenant H. H., R.A.M.C.	2nd York and Lancaster.
DELMEGE, Lieutenant J. A., R.A.M.C.	No. 15 General Hospital, B.E.F.
FARRINGTON, Second-Lieutenant W. B.	2nd Sherwood Foresters, B.E.F.
SMITH, Captain Philip	No. 9 Field Ambulance, Guards' Division, B.E.F.
STEWART, Lieutenant —, R.A.M.C.	8th Field Ambulance, 3rd Division, B.E.F.

Erratum in Last List.—SYMS, Lieutenant J. L., should read SYMNS, Lieutenant J. L.

Birth.

FLOWER.—Rose Violet (née La Touche), the wife of Norman Flower, 57, Headford, Yeovil, of a son, **September 21st.**

Marriage.

GLENDINING—BERRY.—At St. John's Church, Watford, Vincent Glendining, M.S., F.R.C.S., to Frida Alice, daughter of F. Haycraft Berry, M.D., of Oxford House, Watford, Herts.

E. N. G.

GUY'S HOSPITAL GAZETTE.

VOL. XXIX., No. 712.] OCTOBER 23, 1915. [SIXPENCE.

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Passim.

OWING to the temporary defection of the Editor, the GAZETTE will be run for the next two numbers by a syndicate of amateurs whose humble object is to escape a total mental breakdown and, at the same time, to provide their readers with a pleasant sense of anticipation of the return of the former control.

WE have to chronicle another visit from the Zeppelins to the London area on Wednesday of last week, and would respectfully suggest that those gentlemen who feel impelled to leap from their beds and scour Maze Pond should refrain from appearing in fancy dress.

While on this subject we must congratulate the Hospital authorities on the markedly improved lighting arrangements since the last raid, but feel that it would be an improvement if the lights were extinguished before instead of after the arrival of our visitors.

While confessing our ignorance of the local laws of treasure trove, it seems to us a pity that the lost property of the anti-aircraft guns should not rather be deposited in the Hospital Museum than in the seclusion of a private room.

It is pleasing to note that the Borough presented its usual Bank Holiday calm both during the descent of the aforesaid lost property and the inferior imitation on the following night.

THE news of a resumption of activities by several of the games clubs is extremely welcome. There appears to us every reason that men who remain at the Hospital should consider it their duty to maintain physical fitness as well as to improve their medical efficiency; since both are so necessary in the future service of their country. The great majority of games are to be played against sides representing either sections of H.M. Forces or other medical institutions, and the mutual benefit derived is incontestable.

One assumes that every man still in the Hospital has definitely decided that by remaining he is following the shortest path to his ultimate object—a maximum effort for the common cause. Granted this, we sincerely hope that all will take advantage of the chances which these games offer.

The first Rugby match is to be played *v.* the R.N.D., on Saturday, October 23rd, at 2.30 p.m., at Honor Oak Park, and a large attendance would be the greatest compliment we could pay to the organisers.

THE war affects us in a diversity of ways, but we are sorry that there will be no slides for the

Nursing Staff this winter—however, it will be possible to wear nailed shoes again, so why despair?

With regret we hear of the illness of Mr. J. F. Venables from empyema, and wish him the most speedy recovery.

The Hospital is unfortunate in the temporary loss of Mr. C. H. G. Pochin through ill-health. His appointment is one of the most exacting in the Hospital, and though fully realizing the difficulties during the present shortage of men, it seems unfortunate that regular holidays cannot in some way be provided for.

A General Meeting of the Students' Club was held on Tuesday, the 12th October, and it was gratifying to see such a large attendance.

The meeting had under consideration the subject of catering,

The increased interest taken in this department arises from the fact that it is now under the control of the College, and is therefore run for the welfare of the Students.

To help the working of the department on the new lines, the College committee has sought the assistance of the Students' Club by asking the Club to help in the formation of a catering sub-committee which is to consist of the advisory committee on catering of the Students' Club, and the Warden.

The business at the General Meeting was to consider the advisability of enlarging the present advisory committee, and it was decided that the committee should consist of twelve members as follows:—

Four ex-officio members: namely, the President of the Residents, the Treasurer of the Residents, the Resident Surgical Officer, and the Honorary Secretary of the Students' Club.

Four members, nominated from among those residing in the College; the gentlemen who have been so nominated are Messrs. Micklem, Woodruff, Leviseur, and Magill.

Four representatives of the Students' Club, elected at their General Meeting, being:—

One representative of the First and Second Years' Students.

One representative of the Third Year Students.
One " " Fourth "
One " " Fifth "

The object of this committee will be to supervise the Catering Department in all its branches, and to report from time to time to the Students' Club; and the sub-committee will report through the Warden to the College committee, who, of course, have final control over the Department.

It will be seen from the nature of the department and from the constitution of the committee that valuable help can be given by those who wish to do so. Members of the Club are reminded that there is a box placed outside the dining hall in which suggestions can be placed; such suggestions must be signed by the members making them. These suggestions will be considered at the meetings of this committee, and acted upon as thought fit.

Members are urged to keep in touch with the various members of the committee, who will be only too glad to hear any remarks which will assist the committee in finding out the needs of the members.

The Smoking Room, temporarily closed during the change in the catering arrangements, is now open and run as usual, and members who like a light lunch or other refreshments are advised to patronise this portion of the department which in the past has been found a great convenience.

The Hospital and School are indebted to the generosity of Mr. E. J. Anderson, who has given a sum of money for the endowment of a Demonstratorship in Clinical Chemistry.

The Hospital has kindly consented to supplement the annual income of the endowment, and

the Demonstrator will thereby receive an honorarium equal to that given to Demonstrators in other Departments.

The Demonstrator, to be known as the Anderson Demonstrator," will have opportunities for carrying out clinical investigations, and will also devote himself to the problems of cancer research.

The post is now vacant, and applications are invited. These should be sent to the Treasurer at the Superintendent's Office at once. Further particulars of the appointment may be obtained at that office.

Change of Address.

C. J. Crocker, L.D S., from "Branksome," 46, The Avenue, to 47, Portsdown Road, Southampton.

A. G. Delmege, M.D., 33, Westcombe Park Road, Blackheath, S.E.

Lieut. W. A. Easter, R.A.M.C., 68th Field Ambulance, B.E.F., France.

H. Dresing, Esq., R.E., 3rd Bridging Train, B.E.F., France.

N. Mutch, Esq., M.A., M.D. Camb., M.R.C.P. Lond., from No. 8 to No. 26, St. Thomas's Street, London Bridge, S.E.

G. F. Stebbings, Esq., M.B., B.S., Lambeth Infirmary, Brook Street, Kennington Road, S.E.

A. E. Sawday, Esq., "Craig Ard," Elphinstone Road, Hastings.

A. Leigh Allworth, Esq., M.R.C.S., L.R.C.P., West Hill Lodge, West Hill, Sydenham, S.E.

Lieut. L. Horsley, R.A.M.C., St. Andrew's Hospital, Malta.

Lieut. G. F. Charles, 21st Casualty Clearing Station, B.E.F.

Lieut. B. B. Gough, R.A.M.C., 24th General Hospital, B.E.F.

Lieut. P. C. Litchfield, R.A.M.C., 15th Motor Ambulance Convoy, 3rd Army, B.E.F.

Richard Felton, M.B., B.S., c/o Canadian Bank of Commerce, London.

Lieut. E. F. Clowes, War Hospital, Reading.

Capt. G. Y. Thompson, I.M.S., Secunderabad General Hospital, Hardelot, Boulogne.

Maj. R. W. Murray, R.A.M.C. Mess, Fazackerley, Liverpool.

(The Editor will be very glad to receive a post card with notes of any change of address.)

The Teaching of Orthodontics.*

By F. BOCQUET BULL, L.R.C.P., M.R.C.S., L.D.S.

With acknowledgements to the *Dental Record.*

When your Secretary asked me if I would read a paper on "The Teaching of Orthodontics," I gladly answered, "Yes," because I felt that it was a subject that needed discussing. However, on finding that the meeting at which the paper was to be read gave me only a fortnight's grace, my gladness was somewhat tempered, and so I must ask you to excuse me if this paper is somewhat short and scrappy. And as the subject is one better treated by discussion than by a paper, I hope that the discussion on it will be abundant and will lead to some definite points on the subject.

One had hoped that the matter would have been fully thrashed out at the recent International Dental Congress, for under Section X. the Subject of Report on the third day was "The method of teaching orthodontics to dental students." The reporters were Dr. S. H. Guilford, of Philadelphia, and M. Paul Martinier and Dr. G. Villain, of Paris. Three of the speakers were Mr. Cale-Matthews, of Birmingham, Mr. F. W. Richards, of Birmingham, and Mr. Wynne Rouw, of London. Of course, you are all fully aware of how this all fell to the ground.

The teaching of orthodontics at the present time does not, to my mind, appear to be well carried out, inasmuch as it is lumped in part and parcel, at any rate at most schools, with the rest of dental surgery, both in lectures and in clinical instruction. I do not say that the actual instruction itself is at fault, but the organization and method by which that teaching is carried out. Had I had more time in the preparaof this paper I should have written to all the schools in Great Britain and Ireland to have settled this point more definitely. I shall, therefore, be glad if you will bear it in mind this evening that I am attempting to obtain some consensus of opinion as to the better organization and best method of teaching orthodontics.

Now, all clinical teaching in hospitals is, of course, of an entirely different nature from teaching as we commonly understand the word in ordinary schools. In an ordinary school the teacher has only his students to consider. In clinical teaching in hospitals he not only has to consider his students, but also to a much greater extent his patients, and one of the cardinal points to be taken into that consideration must be the

* Read before the British Society for the Study of Orthodontics, March, 1915, and published in the *Dental Record,* August, 1915.

question of time. I have known one or two cases, but only one or two, where the patients liked to attend the hospital, *i.e.*, they actually found a pleasure in it, but this must be out of a total of some 500 that I have had to deal with. The others, from what I could make out, mostly grumbled at the time taken, and some refused further treatment after a certain number of attendances. I want you to make a special note of this point of time saving, because it so very largely enters into our subject, both from the point of view of student and patient.

I am now going to remark on a few of the difficulties that one encounters in the combined teaching and practice of orthodontics. I say combined teaching and practice advisedly, because the one is so dependent upon the other, and it is in that that our chief difficulty lies. Teaching by itself, or practice by itself, would run fairly smoothly, but the combination of the two in a large clinic takes on a much more serious aspect.

The Student.

Under this heading are placed all those factors which tend to make the student a somewhat difficult individual to deal with.

1. Until a student has gained some slight knowledge of orthodontics I am convinced that to the majority of them it is a subject that is, to a certain extent, distasteful; after that knowledge has been obtained then he starts to actually take an interest in his work. This, of course, does not apply to all, but certainly to a very large percentage. It is, therefore, of paramount importance to hold the attention of your student for the first few months. One can compare this rather to the mixing of amalgam, for with the first few revolutions of one's pestle the mercury and alloy take little notice one of the other; once the amalgamation has started the rest easily follows.

2. The treatment of the majority of cases takes considerable time, probably in the student's opinion far more time than the result is worth to him. At my hospital he has to be signed up for six cases—a combined upper and lower case counting as two. I regret to say that if we waited for each man to be signed up for his six cases the period of hospital study would have to be considerably lengthened. The result is that cases have more often than not to be transferred, and I suppose to most of us it is somewhat irksome to take over other people's half-finished work. Again, he often cannot see the end of the case in sight, and as the student to a very large extent works not for the good of the patient, but directly for his own benefit—and I venture to say that he would be unwise were it not so—he is inclined to pay more attention to such work as fillings, etc., at the expense of his orthodontic operations.

Again, most students are of an age when the term "fast" is characteristic of their desires. I am only referring to their professional studies; and so they are liable to become irritated with, and take unkindly to work that does not proceed with their idea of some rapidity.

3. A student is at a hospital for a minimum time of two years' studentship, and I suppose at most hospitals spreads his orthodontic studies over most of that period. Now, to my mind, orthodontics, being a special branch of dentistry, and a difficult one, too, his period of study should not commence until a much later period of his two years. I know that a good many of you will say that under those circumstances he will stand less chance than ever of finishing a case of any length. That is so, but under the scheme of teaching that I shall shortly bring forward that will be taken into consideration. These, although not all, are the chief difficulties from the point of view of the student.

We will now turn our attention to the difficulties with reference to the patient.

The hospital patient is, in a great number of cases, *i.e.*, from the orthodontic point of view, sent up to be treated by a County Council medical officer. They, therefore, have a very bad start off—they are driven to it. In some cases, of course, they come up of their own free will; these cases are far more amenable to to treatment. At any rate it is desirous of starting and finishing the treatment of each patient as soon as possible, with as few visits as are necessary, or, in the same way, the patients cannot see the end of the case in sight, and they also think that they are not getting full value for their time and trouble in attendance. Another point which has struck me as being somewhat farcical is that although one set of officers send up these young patients for attention, another set, the teachers, apparently do all in their power to prohibit attendance, probably due to the fact that monetary grants are made on the number of school attendances; hence the desire that every parent expresses for preferential attendance on Saturday mornings. Again, a fair percentage of orthodontic patients are of such a tender age that a parent or friend is obliged to bring them. This necessitates extra money in the way of fares, and is a fact which is grumbled at considerably. The age of these patients also renders them liable to a great number of childish ailments, and this often makes a break in their attendance, often with serious results. One, I suppose, could go on enumerating these difficulties in endless fashion, but I think that I have stated enough to show that there are such difficulties, and serious ones, from the patient's standpoint.

I.—A Suggested Method.

That lectures in orthodontics should be separate from the lectures in dental surgery. At some schools they

are already so, for instance, at the London Hospital and at Birmingham. A course of lectures in dental surgery, which includes orthodontics, cannot give the attention to orthodontics that that specialty rightly needs and deserves. Further, these lectures should be given during the second year of study, when the student will be better prepared to imbibe them, and not while his attention is taken up with subjects like general anatomy, physiology, etc.

II.—Clinical Teaching.

At the present time at my own hospital, and doubtless at many others, the clinical teaching in orthodontics is given by the six morning dental surgeons, and by a demonstrator who attends three mornings each week. The patient is seen first at the out-patient department by the dental house-surgeon, and is then seen by the hospital almoner, who interrogates the parents as to the ability or otherwise of the patient to attend regularly and pay for necessary apparatus. This is marked down on a special chart which is despatched with the patient to the conservation room, where the surgeon for the morning prescribes the necessary treatment and talks to his dressers about the case, due notice having been taken by him with regard to the matter of payment and attendance. The case is then registered in a book specially kept for the purpose, and when there is a dresser ready for a patient, notice is sent. Sometimes patients are able to receive almost immediate attention; at other times they may have to wait a matter of months. The course of treatment is then carried out by the dresser under the supervision of the demonstrator. In the majority of cases the dental surgeon under whose care the case is, does not see it again until it is brought before him for discharge. For one thing, he has not the necessary time, and secondly, the patient would always have to attend on that particular surgeon's morning, not always a convenient time, either for patient or dresser.

Also, if the progress of the case shows that the originally prescribed treatment needs revision, then it is necessary to wait until the patient and surgeon are both present and valuable time is lost. Again, under this method certain dressers are inclined to neglect their patients altogether, some do not show their patients to the demonstrator for fear of criticism, and a few who are good at their work produce their patients for regular inspection. The patients of the last category are those on whom the demonstrator is able to demonstrate. Thus, instead of having more material at his hands for purposes of teaching than he really wants, the reverse is the case, and the same patients are seen over and over again. I should say at Guy's Hospital each entry of dressers is taken for three months—either for the third-sixth month or sixth-ninth month after entry, the winter entry being a large one being divided into two classes.

These classes are too large to deal with successfully. Sometimes they are as large as seventeen or eighteen men, and as I think it is the more interesting way to teach men by taking them round the chairs and showing each case individually, it is not an easy matter for every man to see the patient's mouth as one is talking. Now I said in the early part of this paper that it was essential to hold the attention of your student for the first few months of his study, and you will easily see how the above method fails to do this. Indeed, the method I have described above is, to put it in plain language, a complete failure. The period mentioned beforehand at which men hold their dressership also is wrongly timed. He is barely conversant with the ordinary conservation room work before he has to launch out into a new branch of study altogether; a study which really necessitates a general knowledge of dentistry before being started.

This may not apply to other schools having fewer students and a smaller clinic than Guy's, but when one reduces both students and patients one also reduces materially the difficulties.

I am convinced that the only method by which the teaching and practice of orthodontics can be carried out on a large scale is to have a separate department entirely under the charge of a dental surgeon appointed solely for that purpose, aided, perhaps, by a demonstrator and most certainly by a special house-surgeon. The method of procedure of practice and teaching could then be as follows. The patients would come up to the out-patient department and would be seen by the house-surgeon. They would then be given a ticket to come up later to see the orthodontic surgeon at his own Out-patients. It would be an advisable thing for the surgeon to attend twice weekly, but this, of course, depends to a great extent upon the size of his clinic. At his Out-patients he would see all the new cases first and from these could select suitable cases on which to talk. At the same time he would prescribe the treatment, and, if a fairly straightforward case, could then proceed through routine treatment by the demonstrator, house surgeon, and dresser, with this proviso that the patient appeared weekly or fortnightly to be seen by the dental surgeon at his Out-patients with other old patients. In this manner a firm grip would be held by the surgeon over all his cases. The adjustment of apparatus in a certain number of the more difficult cases could be performed by the dental surgeon himself with the aid of his dressers.

I come now, perhaps, to the more important part of the scheme, *i.e.*, the instruction of the dressers. I said earlier in this paper that it would be better to give students a three months' dressership during their second year entirely devoted to orthodontic work, or, as an alternative, the afternoons to be entirely devoted to the work, than to have a sporadic acquaintance

with the work spread over the whole two years. I should, therefore, make compulsory a three months' dressership to the orthodontic surgeon in the student's second year. This would have two good results: 1. It would speed up the work, because the student would be more expert with his fingers and, regarding dentistry, with his brains, and also for a similar reason he would learn his work more quickly. 2. An appointment of this nature, where, by regulation, a certain period, or specified time of a certain period to be devoted to this work would put out of court for the student all such excuses as attendance at other lectures or other patients, causing his absence from the clinic. During the intervening time of the surgeon's visits, the dressers would be engaged in seeing their orthodontic patients, and I am bound to say that if they saw to them regularly and properly, they would be fully engaged.

The surgeon would have four periods of three months each during the year, and, therefore, a year's entry of students would be divided into four, probably giving a workable number for instruction by the surgeon at his Out-patients. Of course, it is at this particular time of the surgeon's attendance (Out-patients) that the number of his dressers would matter, for the reason that I stated earlier—only a certain number of students can see a mouth properly while it is being described; but even at the largest schools I think a quarter of each year's entry would not be too great a class.

During this three months' dressership the student would have a varied clinic to study. He would see the new patients twice weekly and would hear his surgeon discuss these cases, and, after seeing them prescribing treatment, the old cases would then be seen and advice given. Thus, the student would see patients in all stages, and, which is more to the point, would under these easier circumstances probably take more interest in and remember more about his study.

At the end of the three months a new set of dressers would come on automatically, and take over the work as a body or firm collectively and not individually as at present. There would thus be no break in the treatment of the patients, and I think that both students and patients would benefit in their particular directions to a very great extent.

Although, as I have said before, this method is applicable to schools with a large number of students and patients, there is no reason why the same scheme, with modifications, should not be applied to schools with lesser numbers.

I have not referred at all to the actual models, etc., to be used in the teaching, leaving this to the discretion of the dental surgeon in charge of the department, and as being matter great enough by itself for a separate paper.

Appointments.

Naval.

The following have been appointed temporary Surgeons:—F. C. Newman, H. F. Percival, to the *Victory* for Haslar Hospital.

Royal Army Medical Corps.

The following temporary Lieutenants to be temporary Captains:—G. D. Eccles, P. Smith, A. C. Hancock, A. C. Jepson, T. H. Body, A. H. Birks.

The following to be temporary Lieutenants:—A. C. Dickson, H. M. Hardy, C. S. Pantin, F. B. Manser, M. E. Ball, L. S. H. Glanville.

The following have relinquished their Commissions:—Lieuts. W. T. Milton, V. Glendinning.

West Lancashire Field Ambulance:—Lieut. J. Walker to be Captain.

London (City of London) General Hospital:—F. D. S. Jackson to be Lieutenant.

Welsh Casualty Clearing Station:—Lieut. J H. Robinson, from Attached to other Units other than Medical Units, to be Lieutenant.

East Anglian Field Ambulance:—E. B. Hinde to be Captain.

Home Counties Field Ambulance:—Major G. T. Williams to be temporary Lieut.-Colonel.

South Midland Mounted Brigade Field Ambulance:—Lieut. H. J. Blackler to be Captain.

3rd/5th Yorkshire Regiment (Princess of Wales' Own):—J. H. E. Winston to be 2nd Lieutenant.

Wessex Casualty Clearing Station:—T. J. Wright to be Lieutenant.

Lieut. Richard Felton, R.A.M.C., to be M.O., 17th Middlesex, 33rd Division.

Attached to other than Medical Units:—Lieuts. A. Morris, J. J. E. Biggs, W. A. Phillips, C. F. Searle to de Captains.

Papers by Guy's Men.

G. A. Wright, Esq., F.R.C.S. Eng.: Amputation by plane circular section.—*The Lancet*, October 9th. 1915.

Arthur F. Hertz, Esq., M.A., M.D. Oxon,, F.R.C.P. Gastroptosis.—*Archives of Radiology and Electrotherapy*, October, 1915.

H. J. Campbell, Esq.. M.D., F.R.C.P.; Exophthalmic Goitre.—*The Clinical Journal*, October 13th, 1915.

Montagu F. Hopson, L.D.S. Eng.. F.L.S.: Apes to Modern Man (III.)—*British Dental Journal*, October 15th, 1915.

W. Beresford Robinson, Esq., M.B., M.R.C.S.: Emetine Hydrochloride. Its uses in mucous colitis, dysmenorrhœa, phthisis, and intestinal hæmorrhage.—*The Practitioner*, October, 1915.

Chronic Pancreatitis.

CLINICAL LECTURE BY W. HALE WHITE.

Gentlemen,—There is a strong desire to assign a cause to every phenomenon; consequently the cause is often wrongly placed, and the evidence upon which it is placed is quite insufficient.

Lately, when a person has suffered from indigestion, the origin of which has been obscure, it has become somewhat the fashion to ascribe it to either pancreatic insufficiency or chronic pancreatitis, often upon extremely slender grounds. Such a proceeding induces considerable scepticism about the cause of the illness in some patients said to have disease of the pancreas, which I must admit I share: therefore it seems worth while to draw your attention to a case in which the pancreas was actually seen to be inflamed.

A lieutenant in the Army was in May last invalided home from France on account of jaundice, which, when he arrived at hospital in London, had lasted three weeks. He had had no pain nor sickness, the urine contained much bile and the motions were pale, the liver was not enlarged. His temperature was 98° in the morning and 99° in the evening; except for his jaundice and the intense pruritus which accompanied it, he said he was perfectly well. The pruritus had been very severe ever since the jaundice appeared. He was covered with scratch marks, many of which had become infected and were converted into considerable sores. The itching prevented sleep, and almost drove him out of his mind. No treatment was of any avail to stop this; the only way we could find to give him relief was plenty of morphia. If he did not have this he got no sleep all night.

The jaundice had lasted too long for the patient to be an ordinary case of catarrhal jaundice. There were no symptoms pointing to gall-stones; he could hardly have a growth at his age, and certainly there was nothing to indicate that he had. There was no evidence of cirrhosis, in which disease the jaundice comes on slowly; indeed, by a process of exclusion we were driven to the diagnosis that he had chronic pancreatitis.

He told us that three other soldiers near him in France also had jaundice at the same time as he, so presumably all four had got infected with some micro-organism, setting up chronic pancreatitis.

Now we were well aware that this disease gradually subsides in a few weeks if left to itself, but in this case the pruritus was so severe and so undermining his health, making him look haggard and ill, that as nothing we could think of, except morphia, relieved it, Mr. English and I determined that his gall-bladder should be drained solely with the object of diminishing the jaundice, and thereby relieving the pruritus.

Accordingly, towards the end of May, after we had had him under observation for a fortnight, Mr. English opened the abdomen. The gall-bladder was not much distended, but the head of the pancreas, both to the sight and feeling, was very swollen and hard; it made quite a considerable tumour, the rounded swelling being about the size of half a golf ball, the lobules stood out prominently, and the organ, although hard, did not feel at all like a growth. After the drainage of the gall-bladder, the jaundice lessened very slowly, and gradually the pruritus got less. You may be surprised that the drainage did not lead to more rapid improvement, but you must remember that it takes a long while for the bile that stains the skin to be reabsorbed from it; hence when the cause for jaundice is removed, as when a gall-stone is taken out of the common duct, the yellowness of the skin only slowly passes away, and in this case the cause of the jaundice, viz., the swelling of the head of the pancreas was not removed by the operation, all that was done was that we had made an exit for the bile externally in the hope that thereby some of the bile which could not get into the duodenum as it should would find its way out through the drainage tube put into the gall-bladder, and hence less bile would be absorbed; this certainly occurred, for much bile flowed out through the tube. As the disappearance of the bile from the skin was slow

so was the passing away of the pruritus, but it did gradually go. The pruritus is only roughly proportionate to the jaundice, often there may be deep jaundice without any pruritus, and sometimes the pruritus may precede the jaundice.

A fortnight after the operation the drainage tube was left out, and a fortnight later the patient went to a convalescent home. When he left there he came to show himself to me, and he was then perfectly well, without a trace of jaundice.

Chronic pancreatitis is a disease which if left to itself gets quite well. I particularly want you to bear in mind that the only reason why this man's gall-bladder was drained was that we hoped thereby to relieve his pruritus, this did not immediately disappear after the operation, so whether we did any good by the operation it is impossible to say for certain, but as the jaundice and pruritus began to lessen after the operation I think we did. That he had chronic pancreatitis there can be no doubt; any one of you who had seen the pancreas at the time of operation would have been convinced that the head of the gland was very considerably inflamed.

Let us now consider the proof of the statement that the disease is one which, if left to itself, gets well. I searched the post-mortem reports of Guy's Hospital for the years 1884–1897, both inclusive. During that time the number of post-mortem examinations was 6,708, and the pancreas appeared to the morbid anatomist diseased or injured in 142 instances —that is, in 2 per cent. of the cases. Many of the morbid conditions—*e.g.*, malignant disease —we need not now stop to consider, but the two following conditions might have something to do with chronic pancreatitis, viz., the cirrhotic, congested or hard pancreas, of which there were 26 examples, and the small atrophic pancreas, of which there were 19 instances.

In 17 out of the 26 cases of cirrhotic, congested or hard pancreas, the patients had suffered from serious organic disease of the heart, and in all but one of the 17 there was marked evidence of severe backward pressure from the heart, as shown by nutmeg liver, œdema of the feet, tough viscera, &c. We may therefore conclude that long-standing difficulty of venous flow due to disease of the heart will cause induration and fibrosis of the pancreas, as of other organs. This conclusion makes us suspect that diseases of the lungs and liver may in the same way lead to the same result, and accordingly we find one case of chronic bronchitis and emphysema, two of phthisis, two of cirrhosis of the liver, and one of thrombosis of the portal vein among those in which the pancreas was congested or indurated. Thus, in 23 out of 26 cases the congested or indurated pancreas was associated with, and was probably caused by, long-standing venous congestion. Of the remaining three cases one was that of a woman in whom a large ovarian tumour had co-existed with pregnancy, which went to full time. In this case we may fairly assume that the induration of the pancreas was due to pressure. One was a case of diabetes, and the third was a man who had pleural effusion, and severe syphilitic change in the liver, in this backward pressure, may have caused the condition of the pancreas. Thus, we learn that the indurated pancreas is always associated with other conditions, and is almost always the result of backward pressure, but the cases in which we suspect chronic pancreatitis clinically are not, as a rule, suffering from other diseases, and have no special association with disease of the heart, so that clinical chronic pancreatitis is not represented in the post-mortem room as the chronically indurated pancreas.

Turning now to the 19 cases of small atrophic pancreas, 16 had diabetes; in one a large mass of growth pressed on the pancreas; one died shortly after admission from a severe burn; the urine was not tested, and in the last no cause for death was found. Now, although glycosuria may occur as a symptom of chronic pancreatitis, we certainly do not recognise this disease as frequently associated with genuine diabetes; and again, jaundice is a very common symptom of chronic pancreatitis, and jaundice is not of common occurrence in diabetes; therefore, we may conclude that the small atrophic pancreas does not represent the terminal stage of what we clinically call chronic

pancreatitis, and as this and the indurated pancreas are the only conditions in 142 cases of disease of the pancreas from post-mortem that could conceivably result from chronic pancreatitis—and we have seen that both conditions have other explanations—we must conclude that chronic pancreatitis is not seen in the post-mortem room, or, in other words, it does not kill. This statement is so nearly correct as to be of considerable use clinically, but it is not absolutely correct, for on looking through 19,000 post-mortem examinations, I came across a solitary case in which the patient, a man aged 42, was jaundiced for seven months; he had an enlarged liver. He gradually became weaker and vomited much towards the end. The head of the pancreas was enlarged and hard, and histologically only showed an increase of fibrous tissue. The pancreatic and bile ducts were much dilated.

The symptom which most often leads to the suggestion that the patient has chronic pancreatitis is jaundice, it was so in the man that forms the basis of this lecture. This indeed is usually the only symptom of which the sufferer complains, there may be a little abdominal pain, but it is not a striking feature, and usually there is no local tenderness; in our patient the temperature was raised to 99° in the evening. There are, of course, the other symptoms besides jaundice due to the circulation of bile in the blood, *e.g.*, pruritus; there is the dark colour of the urine, and the patient usually has pale bulky fæces containing many fatty crystals and smelling foully from the presence of fatty acids. He is usually constipated, and there is some loss of flesh.

Many attempts have been made of late years to discover a means of diagnosing diseases of the pancreas by examining the fæces and urine. There is an admirable critical summary of them by A. F. S. Sladden in the Quarterly Journal of Medicine, vol. vii., p. 455. Unfortunately, extreme pressure of work in the Hospital, owing to the large number of soldiers from the Front, did not in this case allow any opportunity for these examinations, nor were they necessary for the diagnosis was obvious without them. The two most valuable as regards the fæces, are, firstly, the observation of undigested muscle fibres easily recognised by their striation. If a patient has pancreatic disease you may frequently observe a great increase in the number of these in a smear of fæces as contrasted with a smear from a healthy man on the same diet. Secondly, by noticing the fat in the fæces which in cases of pancreatic disease is often visible to the naked eye, as was pointed out by Bright in 1833. The stools—as they were in this patient—may be very bulky, they are dirty white, may glisten from the presence of fatty acids which cause a most disgusting smell, sometimes, but quite rarely, the fat separates out like cream and floats if the fæces are mixed with urine or water in the bed pan. There is some uncertainty as to the importance of a variation in the relative proportion of neutral fats, fatty acids, and soaps; as presumably in pancreatic disease the formation of lipase is diminished we should expect a high proportion of neutral fats, but certainly they are often as well split in pancreatic disease as in health. Speaking broadly, Sladden is of opinion that if the fat excretion relative to the intake exceeds 20 per cent., and if the administration of a pancreatic preparation improves utilization, then there is a strong probability of pancreatic disease.

You might think that the most important test in the case of the urine is that for sugar, and undoubtedly sometimes sugur may be found in a few instances of chronic pancreatitis. But sugar is often absent in disease of the pancreas—*e.g.*, many cases of malignant disease—because the destruction of the pancreas has to be extensive to cause glycosuria, and on the other hand sugar is often to be found in the urine when the pancreas is not diseased, as in patients suffering from alimentary glycosuria, therefore the presence or absence of sugar is not frequently of value in helping us to a diagnosis of chronic pancreatitis. One of the most valuable tests for the detection of disease of the pancreas is that for diastase in the urine; if this is considerably in excess of the normal it is strong evidence of pancreatic disease, and an amount of diastase below normal is against disease of the pancreas if the kidneys are healthy. Why

there should be an increase of the urinary diastase in pancreatic disease is not known.

I have not mentioned many other suggested tests of the fæces and urine, for that they will help in the diagnosis of pancreatic disease is far from certain, but the examination of the fæces for muscle fibre and for fat, and the examination of the urine for diastase may be of great help.

If a few drops of a one in a thousand solution of adrenalin are dropped in the undamaged eye of a healthy person no effect is produced, but if the patient has disease of the pancreas, this procedure frequently causes dilation of the pupil. The explanation of this—often called after its discoverer, Lœwi's test—is difficult; presumably there is, as a result of the pancreatic disease, some substance circulating in the blood which enables the adrenalin to act locally on the pupil. We not only know that this adrenalin mydriasis is very frequently present in pancreatic disease, but that it is not often met with in other conditions. Although the symptoms just described may be of great help in the diagnosis of pancreatic disease, yet you must remember that not one of them is constantly present in all cases, and the diagnosis of chronic pancreatitis can only be reached by a careful balancing of symptoms. Certainly it is sometimes diagnosed on insufficient evidence.

You have already learnt that for all practical purposes it does not kill, and as, when jaundice is a symptom, that passes away, we must assume that the cases get well. A few years ago the gall-bladder was often drained for chronic pancreatitis, but that is not so frequently done now, for it is recognised that the cases will get well if left alone. I know more than one person who has refused to have the gall-bladder drained, and has got perfectly well. Whether draining the gall-bladder accelerates recovery is difficult to say, a large number of cases in which this was done would have to be contrasted with a large number in which it was not done; at present, as far as I know, no such contrast has been published, but this at least we can say that as the disease will get well if left to itself we cannot strongly urge the patient to have the gall-bladder drained, for this is not a trivial operation, and however skillfully it is performed there is always the possibility that something unexpected may arise as a result of the operation. If the case is very protracted or severe, or pruritus is very distressing, you may however explain the situation to the patient, and his wishes will weigh with you whether or not to advise drainage of the gall-bladder.

The diet is a matter of importance, for if the stools are fatty and contain much undigested muscle fibre it is clear that a farinaceous diet is best. The bowels should be kept well open. Calomel is useful for this. Probably the disease would subside more quickly if the patient kept in bed entirely, and certainly he should stay in bed at first. You may give some of the various preparations of pancreas in the market with a view of compensating for the deficient secretion.

We know nothing of the cause of the condition. It is tempting to assume that it is due to a microbic infection spreading up the duct from the duodenum. That in our patient the cause was an infection is rendered very likely from the fact that others had the disease and the patients' temperature was slightly raised.

Guy's Hospital Missionary Society.

The Missionary Society was disappointed of its first winter meeting, which had been carefully arranged for "change" night, October 7th.

Dr. Ferguson-Davie, wife of the Bishop of Singapore, came up from Netley to speak, but the meeting was necessarily postponed.

On Thursday, October 28th, Mr. H. H. Weir, M.B., late of Corea, has promised to come, and we hope for a large audience. Men as well as women will be welcome. The time is 8.15 p.m.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the Gazette *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Serbia.

III.—SALONICA.

A drowsy ship of some yet older day . .
Thought I, who knows, who knows but in that same
(Fished up beyond Aeaea, patched up new,
—Stern painted brighter blue),
That talkative, baldheaded seaman came
(Twelve patient comrades sweating at the oar)
From Troy's doom crimson shore.

J. E. Flecker.

For the whole day we have been travelling through the inner belt of islands. The Piraeus we left the evening before, the sun setting in a blaze of splendour behind Mount Hymettus, its rays falling for an instant in dazzling radiance on the snowy masonry of the Acropolis, the angry tumult of the winter sky fading through the gamut of purple, gold, and rose to a lustrous darkness. But this morning we have nothing left but a dull monotone, a symphony of greys and sage green, of bare silhouettes and mist-topped peaks.

Stopping for an hour or so at some little port which sends its paraphernalia of quays and custom house to the water's edge, whilst it remains itself like some timid, woodland thing secure on the heights, we cruise at half speed amid rocks and shallows, the panorama unfolding in a weary litany of sameness. Time after time we see a little township perched precariously on the cliffs, gleaming like distant snow, seemingly unapproachable, and it is only near at hand that we note a narrow trackway from it down to the shore. The isles themselves are arid and dull; one feels constantly that with such admirable material at hand they ought to be more picturesque; as it is, they leave one cold and uninspired.

The boat itself, an island tramp, is full of a miscellaneous population of country folk, priests, and soldiers, who live in a state of wretchedness unimaginable. Last night it blew a gale, but I draw a veil over the sight. Walking through the steerage, one is tempted to wonder if they ever move at all. Perched on broad shelves raised some four feet from the deck, benign archimandrites cheek by jowl with peasant mothers and their offspring, grave Arabs, the ubiquitous Albanian, Greek soldiers, returning to their posts or home on leave, the miscellaneous flotsam and jetsam of travelling humanity, eat, jest, and sleep in utter disregard of their neighbour.

On the upper decks, unshaved, dyspeptic Greeks sit passing strings of little beads through their fingers. They are not praying, though you might be tempted to think so. It is merely an agreeable way of passing moments otherwise idle. Here and there dotted about the ship are little *eikons*, the figure stamped in bas-relief of tin, the faces dark and brooding. Before each burns a tiny candle night and day.

A merchant from Corinth expounds to me at great length the ideals of modern Greece as we pick our way gingerly along the encumbered decks. At intervals a hideous effluvium rises from the huddled peasantry below, and the "ideals" appear for a moment as the vapourings they really are.

As the boat anchors in a little harbour, a huge ferry boat can be seen pulling out from the shore, laden high with live stock, more passengers, and the humble *lares et penates* of a herdsman's family. For a while all is hubbub. The shrill chafferings of the boatmen—Greek is the noisiest language on earth—the rumble of the winch, the bleating of goats, combine in a shrill crescendo of sound.

As we advance slowly up the Gulf of Salonica, the evening air blows chill from the coast, and the mountains in the light of a gibbous moon show gaunt and enormous, their fantastic silhouettes a little theatrical in their unreality. The swish of oars sounds gradually approaching on the port bow, and a soft chant breaks softly above the stillness. As the boat passes, the words of the simple Anacreontic lay rise to the ear, and the Corinth merchant pauses, touched, perhaps, by the spirit of the place, and the ideals of modern Greece fade into insignificance. Soon we shall be at Salonica, with its ebb and flow of a mean, residual life, its petty peddlings and sordid ugliness. Only now upon the untroubled mirror of the twilight sea does the clean remoteness of those distant crests figure with the intangibility of a quest immaculate.

I confess on arrival I thought Salonica an unpleasant town. It seemed to combine the seedy, cosmopolitan rakishness which is common to every large seaport with a disreputability peculiarly its own. Returning after Serbia I hailed it as a haven of delight, regarding its bloated bar and tedious cinemas as charming manifestations of a civilisation I had despaired of seeing again.

But that is another story. Principally my impressions of Salonica centered round Charlie, the rascally head porter of the hotel. I suppose every journalist, red cross unit, or relief worker sooner or later falls into Charlie's clutches. I have seen references to him by "Our Special Correspondent" (pressed for copy) in places as diverse as Naples, Marseilles, and London, and I have no reason to believe his reputation for minor villainy is confined to this hemisphere. As you enter the gaudy foyer of the hotel, a figure familiar to the readers of a once flourishing journal as "Ally Sloper" would approach and inquire your wants in American English. Lured by his siren smiles, his boasted capabilities of dealing with extortionate boatmen, cabdrivers, and baggage porters, you would leave your minor business in his hands. For a

day or so all would go well, then, perhaps, annoyed at the non-arrival of some crates or bales you specially needed, you would demand Charlie. The office clerk then adopted one of two tactics: either a complete ignorance of any language you could possibly employ against him, or the assurance that Charlie was at lunch, tea, dinner, supper, or in bed, and that no guarantee could possibly be given as to when he would return. After the expenditure of much time, patience (and language) you probably succeeded in extricating yourself and your baggage from the muddle, and, returning to the hotel exhausted after a day of crass stupidity and official pettifogging, would be greeted by the beaming Charlie with a long bill for services rendered.

An enterprising *impressario* would have secured Charlie for the pictures—Charlie beguiling a fresh victim, his massive form radiant with a busy helpfulness; Charlie on his dignity, appealing to his reputation—a fine figure this, marred a little by the protruding paunch; Charlie indignant, his honest purple visage flushed with righteous anger; Charlie found out, the pale blue eyes watery with sorrow, even the well-developed carbuncles on his nose taking a humbler tinge. The theme, you see, is capable of infinite variations. The last time I saw him he was mute and appealing: some English unit had refused to pay his very moderate fee for services rendered, would I as an Englishman see that a poor hardworking fellow was not cheated of his deserts, etc.

Salonica is too recently Greek and too lately Turkish for a fair idea to be formed of its possibilities under either. One-third of the population is Jewish, and there is a large Moslem and Portuguese element. As to the language, it would be difficult to speak. I suppose officially it is Greek, but Turkish, Arabic, French, Spanish, and Italian all seem to be spoken with fair fluency in shops. In the bazaar quarter—an extensive and richly picturesque district this, though spoiled for the tourist of moderate means by the meteoric advent of Sir Thomas Lipton whose unbounded wealth had left the population with the usual theories about English milords—even electric trams and a general vulgarisation could not destroy the relics of the changeless East.

Of the history of Salonica I confess I know nothing. In the old quarter a battered but still interesting triumphal arch commemorates Hadrian's victories over the Macedonians, and since Phœnician days it has been a coverted seaport, giving access as it does to a valuable hinterland.

In a forgotten bye-street a lovable old archimandrite showed me over a bare circular mosque, which, to judge by its inscriptions, must have had a chequered career. On the roof were frescoes of an early Christian character, a crucifixion and a last supper, recalling in their *naiveté* the work of Cimabué and Ghirlandaio at Florence. Partially obliterating these were Turkish inscriptions from the Koran and the conventional arabesques of flowers and tracery. Now the place was lit with a blaze of candles, incense filled the air, and *eikons* were posted on every available wall and pillar. Leading us through a little cloister, the priest showed us a miniature burial ground, walled in on every side and filled with crumbling Moslem graves. Linguistic obstacles prevented any explanation of this curious blending of faiths; I can only suppose that the Greeks had appropriated the building after 1912, but their respect for the little cemetery seemed kindly and not a little touching.

Perhaps the most interesting part of Salonica is the quayside. Stretching from the White Tower to the modern harbour, this former a massive donjon built by some byegone tyrant for the incarceration of Christians, it presents more types of multi-coloured life than any other part of this very vivid town. Here are boats, the same, surely, that carried Odysseus and his sturdy crew back to Ithaca, rigged with two or three primitive sails, the *vela latina* of the ancients, each painted with a vermilion sun, their sterns bright crimson or ultramarine, their bows decorated with an eye to ward off ill chance. It is easy to believe that the type has been handed down unchanged from the days of Tyre and Sidon. A romantic trade theirs, coasting year in, year out, amid the dream islands of the greater and lesser archipelagoes, going out laden with clothstuffs and the simple manufactured articles required by the herdsmen and vine growers, and returning laden with the rich produce of the isles—black olives, golden oil, potatoes, grain, and great casks of deep red wine, rough and generous. The mariners move gracefully amid the spars and coils of rigging, singing as they work, or stretched full length on the decks laugh to show their gleaming teeth as the girls walk slowly past, and expectorate over the side with careless elegance.

They are not beautiful, these boats; viewed near at hand and disassociated from the arts of use, a critical eye would pronounce them heavy and lacking in beauty of line, but see them scudding across the wind-flecked bay, sails reefed, bows high in foam, and they are transformed at once to things of vibrant life. The buildings along the seafront are garish enough in all conscience: a few bad hotels and beer halls, a couple of cinemas, and a solitary music-hall, called, quaintly, the Odéon. In the evening it would be pretty lively, filling up towards nine o'clock with the vast floating population of the docks, Dagos, and Arab half-casts, Jews, Spanish Americans, and an occasional British mate or skipper. The whole floor space was covered with chairs and beer tables, among which a hideously mutilated waiter with one eye pushed his way, slopping drinks down the necks of the unwary. (They told me that he was an American mutilated as

a child, but it is the fashion to ascribe all such barbarities to the Turks.) The walls rose sheer in four or five tiers of miniature boxes—dovecots they call them in Italy—just large enough to accommodate four people at the risk of asphyxiation.

The turns were, in the main, frankly unpretentious. Trick cyclists and jugglers, elderly soubrettes of all nationalities and a troop of creole ragtime dancers who were apparently the means of introducing the syncopated measure to the population of Salonica. Rarely have I seen such a furore. Elderly Greeks, run to fat, swaying to and fro to the strains of "Dixie," their rickety chairs creaking and groaning, every moment a fresh peril to their lives. Grecian matrons seemingly on the verge of apoplexy, humming, crooning, roaring the seductive melody till the veins stood out livid on their brows like weals. All the youth and beauty of the town, scorning censure, singing and rocking in a joyous *abandon*. Such is the effect of ragtime on a simple and unsophisticated race.

G. H. F. G.

Nursing News.

British Expeditionary Force,
September 15th, 1915.

"We are in a beautiful building, a block of a large lunatic asylum; the wards are nice and bright and airy, and the place is well adapted for a clearing station. I have the top floor to myself, two wards with 50 stretchers in each. Since I came we have had 70 men, but we have not been busy, and there are two other casualty clearing stations in the town, and we each take in every third day, and it is our turn to-morrow, and, judging from the continuous terrific bombardment of the last few days, I should think it is more than likely we shall be busy.

"In a field close by there is an aerodrome with about a dozen aeroplanes. Our airmen are very busy; they start about 5 a.m. every morning. Now we have become quite accustomed to the noise of the engines, and they do not wake us up.

"Last October the Germans were here. Von Kluck billeted at the asylum, and our wards were used as stables, those on the ground floor.

"We are just outside an old-fashioned market town, but it is the dirtiest place I have ever been in, worse than the London slums. Our "mess room" is the front parlour of a French cottage, and the good lady of the house does our cooking, and does it well. It is a few minutes' walk away, but it makes a nice break in the day to have a little walk and a breath of air before one's meals.

"We sleep in the building, using our camp furniture, and for my dressing table I have two Red Cross packing cases. We are able to have a bath every night, a great luxury, not often to be indulged in since we came to France.

"We have a nice little chapel; it is curtained off with brown blankets at the end of a large room in the basement. We have a Church of England chaplain attached to this hospital."

From Nurse Pearse, Guy's Institution:—

Malta,
October 17th 1915.

"Now to try and tell you a little news.

"Nurses Finlow, Foxon, and myself are together, though we all have charge of different wards. We meet occasionally at meal times and are sometimes off duty together. Our little jaunts are generally into Valetta, which is not far, and there is a quick way of getting there by crossing a ferry which costs ½d.

"The hospital is a fine building which was originally the Government Elementary Schools. It has two floors, one for surgical cases and one for medical, though they seem to be chiefly medical at present. We have no wounded yet. The hospital has only just been opened, and was not staffed except by orderlies until we arrived on Tuesday, so they were not able to admit any bad cases. I do not really think we shall get much in the way of surgical work, as they will not operate more than necessary as the climate does not favour healing.

"I have charge of seven small wards of eight beds each. There is a lot of running about to do, and as the floors are all stone, we feel very footsore when we come off duty.

"The weather is lovely, just like a very nice English summer, but it is really too hot to go out in the afternoon. The evenings are lovely, and we are quite close to the water. We have a very nice matron. She has just come from another hospital, and the matron-in-chief is very nice, too, so we think we are very lucky and hope we shall not get moved yet.

"I have had lots of mosquito bites, and the flies are awful, so I find matron's killer very useful.

"Someone is giving a concert at the hospital this evening, but I feel too tired to go, so thought I would sit down and write to you. We have a little walk to and from work, as we have our quarters in an hotel. We are able to have cups of tea which we enjoy very much, as the tea we get here is not very nice.

"We are all longing to get letters. It is best to address everything to "Matron-in-Chief, Malta," as, if we get moved from one hospital to another, she always knows where we are."

The Arrangement of a Pathological Museum.

By G. W. NICHOLSON.

The student, when he takes up a text book of medicine, and reads up a disease, finds a description of the primary lesion and of its ætiology, symptoms, and diagnosis. He next turns to the secondary lesions, the tissues in which they occur, the complications that may set in, and so on to the end of the chapter. On going to the museum, in order to familiarise himself with the appearance of the conditions he has been reading about, he is obliged to spend a large amount of time and energy in going from one section to the other. He looks at skins, bones, muscles, viscera, the vascular system, with an occasional excursion to the brains, and, indeed, to almost every section of the museum. The reason of this is that the specimens in nearly every museum are classified in a strictly anatomical manner, namely, according to organs.

But the body does not work according to organs only, nor does a disease limit itself to one particular system. Almost any part may be affected. The question therefore arises: Is our present method of classification the best, or is there not a better? The alternate classification is one according to disease and not according to organs. After all, the museum is called a museum of pathology. Should we not expect its arrangement to follow as closely as possible the ravages of the numerous ailments our bodies are heir to, and not merely to marshal shelves of bottles, each shelf containing specimens of an organ affected by diseases, whose ætiology and course are as diverse as possible? Our present system is cut and dried, and permits of specimens illustrating all the conditions by which a viscus is affected being collected together in a small space.

Now this is in itself a very valuable classification. At one time great progress was made in differentiating between the appearances of the numerous lumps that are to be found in an organ. Some were found to be solid, whereas others were cystic; some were tough, and others soft. They were all called tumours. Now, however, we know that they are caused by a great variety of agents. A cyst may be the result of an invasion by protozoa, metazoa, bacteria, or cancer cells, or may be due merely to retention of secretion. It was not until physicians (pathologists had not come into existence in those days) realized that the really important factor is not the appearance, but the ætiology of a lesion, that true progress was made. They were then able to understand differences in structure in the light of differences in causation. Their knowledge became more physiological, and increased by leaps and bounds. But the arrangement of the museums did not keep pace with the development of knowledge. It should be possible for every enquirer to be able to see put together a collection of all the lesions that arise from the same cause, together with specimens illustrating the complications. He would then go away with a far sounder knowledge of the workings and interrelation of the different parts of the body, and of the manner in which an injury to one part reacts on many others. It may be objected that such a museum will have an incongruous appearance. But will it? At present the diseases, the real causes, suffer in this way. The new arrangement can only offend our preconceived and old-fashioned opinions. If we were to enter into the meaning of morbid processes, it would soon become rational and pleasing to our eyes. Both such of us as teach, and such as are being taught, would find their labours considerably lightened.

Down the Boro'.

When we came on the District
We thought we'd have some fun,
It was too hot to walk about—
We found we had to run.
The cards came in like lightning,
The bell was never still;
We grabbed our cloaks, snatched up our bags,
And started with a will.

Tearing along, right through the throng,
Hoping to be in time,
Ninety-nine stairs, mounted in pairs,
Panting, we finish our climb.

If "Father, dear," looks big enough
We let him have the bag.
We're careful now, for once before,
A nurse was badly had.
A small boy dropped it on the way,
And dashing home, he cried,
"Shall I be hanged? I've dropped the bag,
And killed the baby inside."

Trying to smile, cursing meanwhile,
We pick up our things in haste;
Some are intact, though badly packed,
But everything else is a paste.

When we go on the men's side
A "B.B.A." greets us;
Five times "F.A.'d" that very day,
Past midnight now! no bus!
"Where does she live?" we ask papa;
"Guinness's Buildings, not very far."
We don't say much, we think the more,
We've had some cases there before.

Gamps in that part seem sick at heart
Watching the nurse walk in.
"We wanted the Dr. who's been here before,"
Is the welcome we get as we enter the door.

The Gamp, looking sulky, begins with her tale,
We've heard it so often, it's getting quite stale.
"That Dr. who went to Mrs. Adair,
With a nice kind face, and long black hair.
Oh! such a nice gentleman, he could crack a joke,
He said to me whilst having a smoke—

"Come along, Mrs., I'll leave it to you,
I've met you before, you know what to do."
No wonder they hate us, we let them do nothing,
But fetch the hot water, and do all the grubbing.

When "the Drs." come on our side
They get their share of hate;
We sit at a case for hours and hours,
They "have no time to wait."
We tidy up, and bath the babe,
They tear off in a hurry;
They leave a slip for odds and ends,
And that is all they worry.

Oh, what a life! we all fare alike,
From some we get smiles, from some frowns.
But we'll strugle along till we joint the great throng,
With, *perhaps*, a new gem in our crowns.

JUNE.

Obituary.

PROFESSOR MINCHIN, F.R.S.

We regret to announce the death of Professor Minchin, at the early age of 49.

Professor Minchin was educated at Keble College, Oxford, later obtaining a Fellowship at Merton. Much of his time was spent in teaching, first at Guy's, and later at University College, where he succeeded the late Professor Weldon, as Jodrell Professor of Zoology.

During this period, Professor Minchin devoted most of his attention to the embryological and anatomic characteristics of the sponges, until such time as he was appointed to the Chair of Protozoology at the University of London, where he did much valuable work on the parasitic protozoa. Professor Minchin did not, however, devote his whole time to these branches of Zoology, for he was well known and greatly respected in general scientific circles, and for many years he was a member of the Council of the Zoological Society of London, serving on several committees of that Society as a Vice-President.

It was during his days of teaching Biology at Guy's that Professor Minchin became intimate with the Hospital, and only those who worked under him or knew him personally can realize what fate has done by cutting short so distinguished a career.

Though never of robust health, it seemed reasonable to expect that Professor Minchin had many valuable years in front of him, and we condole most sincerely with his relatives and friends in the great loss which they and the scientific world in general have sustained.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Elementary Anatomy and Physiology: for Junior Students, Nurses, and Teachers. By H. C. Barclay, M.D. (Baillière, Tindall & Cox.) 6s. net.

This is an extraordinarily interesting and up-to-date book. It is written in the style of lectures, and intended primarily for hospital students and nurses, but it should also be a real help to High School teachers in these days when sex physiology is so much discussed.

Part I. consists of 17 lectures on anatomy, illustrated by many plates and diagrams.

Part II., physiology, is preceded by some interesting chapters on elementary biology, the author regarding both anatomy and physiology from the wider view of the biologist.

Part III. is devoted to embryology, and Part IV. to comparative anatomy.

The plates and illustrations throughout are good, and Dr. Barclay writes in such a fascinating way that the reader becomes absorbed at once. The book is well bound and beautifully printed, and the fact that the type was set up by Japanese printers, who knew not a word of English, and that the author was obliged, owing to the outbreak of war to leave Japan without supervising the completion of his book, adds considerably to its interest.

Hints to V.A.D. Members in Hospitals. By E. C. Barton, Matron of Chelsea Infirmary. (Macmillan & Co.) Price 6d.

Miss Barton realises the difficulties which Voluntary Aid Workers are bound to meet with in a hospital, and aims at showing them what is expected of them, and how the knowledge they already possess may be turned to best account. The notes on "hospital etiquette" are excellent, and Miss Barton gives most valuable advice as to personal health and professional behaviour, together with many useful hints on ordinary routine and ward work.

Medical Emergencies. By James Rae, M.A., M.D. (Scientific Press Ltd.) Price 1s.

This is a most thoroughly practical little book. It tabulates the different emergencies likely to arise in the course of disease, and suggests simple methods of dealing with each. Many useful hints are given as to things likely to be needed by the physician, which a nurse may prepare, and so prove herself of valuable assistance when the emergency is great and every moment of consequence.

Dr. Rae also gives some simple prescriptions for the relief of hiccough, flatulence, etc., which come within a nurse's province, and which are often so difficult to relieve.

Text Book of Forensic Medicine and Toxicology. By Professor Buchannan, M.D., F.R.C.P. London, &c. 8th Edition. (Edinburgh: E. & S. Livingstone.)

Previously Husband's Forensic Medicine and Toxicology and Public Health, this book is now issued in two parts; the subject of Public Health being dealt with separately. The general arrangement of this book is the same as in previous editions. Section I. dealing with forensic medicine, and Section II. with toxicology. In both sections the general arrangement of the subjects of the chapters is the same as before.

Section I. starts off with a short introduction to the genesis of medical law. Chapter I. deals with legal and criminal procedure as exercised in England, Scotland, and Ireland. Chapter II. discusses medical evidence generally, and in it some new illustrations of finger-prints are introduced. The chapters which follow deal in order with death in its various forms, post-mortem examinations, assaults, blood stains, and tests, burns, scalds, contusions, suffocation, &c., drowning, death from cold, &c., offences against chastity, pregnancy, &c., fœticide, infanticide, inheritance, legitimacy, &c. Chapter XVI. has been brought fully up to date in the subject of insanity.

Section II. includes toxicology, and the first chapte gives various definitions of a poison, and treats the sale, action, classification of poisons, general evidence and treatment of poisoning, and general methods for examination for poison. The following chapters deal with the various poisons, conveniently classified individually.

One of the most striking improvements in this new volume is the general printing of the text. The various headings are in bolder type. and italics have been introduced in several places to great advantage. A few new illustrations have been added which help to enhance the value of the volume.

We can confidently state that neither practitioner nor student will be able to find a clearer and more comprehensive text book on this important subject, and we wish this new edition all the success it deserves.

Pass List.

University of Cambridge.

The following candidates have been approved in the examinations indicated.

Second M.B. (Pharmacology and General Pathology): J. M. Bickerton.

Conjoint Board in England.

Second College (Anatomy and Physiology): A. Y. Massouda has been approved at the above examination.

Royal Colleges of Physicians of London and Surgeons of England.

At the First Professional Examination, held on Sept. 28th, 29th and 30th, and Oct. 1st, the following candidates were approved in the undermentioned subjects:—

Chemistry and Physics.—Mohammed Abdul Razzak Khalifa, Gerald Baeyertz Kirkland.

Physics.—Eric Hardy, Guy Kingham Reeves.

Biology.—Stanley Godsill, Cyril Bernard Dix, John Edwin Hardy.

At the quarterly examination in Practical Pharmacy, held on October 7th, the following candidates were approved:—Edgar Scott Bowers, Eldon Munro Litchfield, Lionel Alexander Burke Moore, L.D.S.

Royal College of Surgeons of England.

At the Preliminary Science Examination for Licence in Dental Surgery, held Sept. 28th and 30th and Oct. 1st, the following candidate was approved in the undermentioned subject:—

Physics.—Herbert Shires Murray.

Births.

BIRKS.—On the 8th inst., at Wilsbury, Brading, Isle of Wight, to Lieut. A. H. Birks and Mrs. Birks, a son.

CHAPPLE.—On Oct. 13th, at 18, Devonshire Street, London, W., to Mr. and Mrs. Harold Chapple, a son.

Deaths.

STAMPER.—On the 5th inst., at Hackney Infirmary, Geoffrey Cook Stamper, M.R.C.S. Eng., L.S.A. Lond., Temporary Assistant Surgeon, of Pembroke Dock, Pembrokeshire, second son of the Rev. J. G. H. Stamper, late Vicar of Burbage, Buxton, in his 58th year.

LANG.—On the 26th inst., at Toorak. Melbourne, Australia, Archibald Grahame Lang.

E. N. G.

GUY'S HOSPITAL GAZETTE.

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Passim.

COMING, as it does, at a time when some of our members are leaving us, more directly to serve their country's needs, this number of the GAZETTE will, it is feared, be of even more spasmodic and piecemeal generation than the last, and after a period of inactivity and suspense, with impending rather than any actual thrills, it must humbly take its place in the endless ranks of those whom this war has shaken but not dismayed.

IT must have come as a surprise to many to be jolted, even in our hospital seclusion, by the most recent of the apparent governmental activities. It is certain that several of those requested to consider their positions must find themselves hard pressed for even a few free moments to do so, and although we can appreciate the value of the suggestions as applied to some of our junior readers, it seems a curiously mistaken zeal which prompted the despatch of the now famous letters to some of the most tireless members of our permanent staff.

Also are we anxious to know how the profession, mature and embryonic, will fare in face of press-threatened public vengeance which is most surely to fall on those unshielded by the khaki armlet! Most certainly many have braved much unspoken criticism during these weary months of war, but in the event of this suggested active demonstration we feel that a distinguishing mark is indispensable, be it only a heavily-weighted staff of office.

WE have no further Zeppelin raids to chronicle or discuss and cannot refrain from wondering whether the Metropolis fully appreciates its debt to our far-seeing authorities. Since the obliteration of the Hospital beacon our visitors have, in rumour at least, on more than one occasion failed to find their way to their old hunting grounds, and have sadly disappointed certain more circumspect members who formerly, with such excellent results, turned over that last halfpenny in their pockets as they gazed at the shimmering raider.

AN editorial request for letters from our many friends at the front has met with an excellent response, and abundant news, descriptive and personal, has been sent to us. We are much indebted to the writers for their trouble and remembrance which has in many cases survived the most nerve-trying circumstances.

THE revival of some few of the Hospital games has been an unqualified success, and the reappearance of a Guy's XV. at Honor Oak Park, while sometimes bringing memories of days which had seemed for ever lost, left both

players and spectators with a welcome reminder that there still remains, even in these dark times, a lighter side. We wonder whether Harris would not be well advised to make extra charge for teas served in private rooms and out-of-the-way places. Anything in the cause of Charity!

It is with the greatest pleasure that we hear of the award of the Military Cross to Lieut. Allan Minns for conspicuous gallantry at Suvla Bay on August 30th. All will offer him the sincerest congratulations.

We deeply regret to read of the death, in his 19th year, of Rifleman W. A. Harris, of the 16th City of London Regiment, the eldest son of our popular groundman at Honor Oak Park. He was killed in action at Loos on September 25th, 1915. Laboratory assistant in the Pupils' Laboratory of the Dental School from 1912 to September, 1914, when he was among the earliest to enlist, he will be always well remembered by those who came in contact with him, and his death adds another name to the list of those who have died in the great cause. We offer our sympathy to his friends and relatives in the sad loss they have sustained.

There are so many ways in which we can help those bearing the full force of our present national troubles that we fear most have already decided upon their particular sphere of activity, but we hope the Hospital will not omit, when within its power, to aid certain estimable daily papers in their attempts to remind and reunite good friends and closer relations whom this war has so cruelly divided.

As we go to press we hear the news of Mr. P. D. Scott's approaching marriage. We offer him our sincerest good wishes and congratulations.

We are requested to ask any late scholar of King's School, Canterbury, to be good enough to communicate with the Librarian.

The Value of Sugar in the Treatment of Typhoid Fever.

I.—Introductory.

The question of diet in typhoid fever has always excited discussion. The clinician's chief difficulty has been to reconcile his concern for the patient's very apparent needs with the caution which, on anatomical grounds, seemed to him to be essential. In the presence of hunger and rapid emaciation, nothing is more trying than to feel compelled to adopt a semi-starvation routine. It cannot be denied that the tendency of late years has been the direction of liberality, but diets of "milk," "fluids," and even "whey" are still widely employed, though little scientific evidence in their favour is forthcoming. This rigour would appear to be the outcome, on the one hand, of the old conception that it is necessary to "starve a fever," and, on the other hand, of the fear of hæmorrhage and perforation. Physiological experiment and pathological findings do not bear out the necessity for such caution. We know that in normal life the majority of real foods are already in a fluid or semi-fluid state by the time the ileum is reached, and there is no evidence to show that in typhoid fever the necessary ferments cease to be produced in sufficient quantity to deal with reasonable amounts of carbohydrate, or of protein and fat if given in suitable form. In point of fact, no food is capable of reaching the small intestine in a more solid state than the casein and soaps of milk, for it is by no means an infrequent experience at post-mortem examinations to find in the ulcerated area large "milk clots, which are presumably more capable of exciting undue peristalsis than the products of other true foods at this stage of their transit. Indeed, the presence of such clots here, and sometimes in the stools suggests that a "milk diet" may contain more than a "reasonable amount" of protein or fats, since the patient has failed to convert it all to his own use. Furthermore, the caloric value of the customary three pints of milk is insufficient even for the requirements of a normal adult male in bed, while a febrile individual obviously has a far greater caloric output and consequent requirements.

The object of this paper is to urge the necessity for a very considerable carbohydrate element in the diet of typhoid fever patients, especially in the form of sugar.

It is becoming an accepted view among physiologists that protein is not always a physiological essential (there being no way of storing nitrogen in the body except by body growth), and that the body does not, as formerly supposed, use protein by choice. Fat, demanding a complicated splitting process, and being also unpalatable, cannot be given in large quantity.

But carbohdyrate, the main source of muscular and all vital energy, can be given in comparative plenty, and the speed and ease of the assimilability of sugars, together with their high calorific value for their small bulk, renders them a very valuable food in disease, just as they are valuable in the case of physical fatigue. That athletes, soldiers in the field, and children have a definite "sugar hunger" has been fully recognised and advantage taken of the fact. Theoretically, sufferers from a long and exhausting disease such as typhoid fever might be expected to manifest a similar hunger, and experience shows that they actually do so. It may not be out of place before proceeding further to summarize briefly some of the modern views on metabolism, with especial reference to the metabolism of carbohydrate.

II.—Metabolism.

The carbohydrate of the food is converted into glycogen in the liver. This glycogen is made directly from dextrose and lævulose, doubtfully from galactose, and only indirectly from protein and fat. With a working digestion, cane sugar and starch may be considered to count as dextrose and lævulose. Muscular activity is much the most effective way of diminishing the glycogen of the liver. The idea is gaining ground that muscular energy comes mainly from carbohydrate. protein, and perhaps fat being transformed to carbohydrate before they can be used in this way. Intermediately lactic acid is formed from the carbohydrate in the muscle. The Cambridge view, based on the work of Fletcher and Hopkins, and developed from the physical standpoint by A. V. Hill, is that every single contraction of skeletal muscle involves the liberation of lactic acid in the muscle, which acts on the muscular substance and so causes the shortening. Briefly, recent evidences support the old view of Claude Bernard as to the sequence of events. Ingested carbohydrate supplies the glycogen of the liver from which in turn are supplied (1) the sugar of the blood; (2) the glycogen of muscle; and (3) the energy of muscular contraction.

It is further shown by Cathcart and by Douglas that muscular activity does raise the respiratory quotient, as it should do if carbohydrate is mainly used.

In regard to heart-muscle, Locke's experiment with the surviving mammalian heart shows that the heart keeps going better if dextrose be added to the perfusing fluid; while Starling's heart-lung preparation uses up sugar added to the blood, and glycogen in the heart substance at a rate dependent on the activity of the heart.

The sugar of the blood is remarkably constant (0·1 per cent.), even in starvation, although it is presumably being used up all the time. The old idea that the body uses protein by choice is no longer tenable, the explanation of the immediate excretion of nitrogen from the food being that, except by growth, there is no way of storing nitrogen in the body. It is a general proposition that when the young increase in weight very rapidly, the relative amount of protein in the milk is high, obviously for the purpose of building tissue, not as a source of energy. When there is a lack of carbohydrate, diacetic and oxybutyric acid appear in the urine, and this may be regarded as indicating that carbohydrate is being made from protein and fat.

Acetonuria, except in the presence of diseases of the liver, signifies that the body is short of carbohydrate. It may or may not be associated with clinical symptoms of acidosis, a term which throughout this paper is only used as indicating a state in which these bodies are present in the urine.

In the light of theory, as well as of the experience on which this paper is based, it may, perhaps, be justifiable to attempt an analogy between prolonged fever and muscular exertion and their respective influences on body tissues.

III.—The Analogy of Prolonged Fever and Muscular Exertion.

Calorie consumption takes place either as the result of work done or heat produced, and it is obvious that both in muscular activity and in a fever usually lasting three or more weeks the calorie consumption must be above the normal. In both cases it may be assumed that carbohydrate, the chief source of heat and energy, is first drawn upon, and that it is required in larger quantity than normally. In both cases if insufficient carbohydrate be supplied, the fat and protein of the food, and later the fat and protein of the body, are called upon to supply carbohydrate, and similar clinical evidences of this eventuality are recognisable. The disappearance of body fat, the manifestation of "sugar hunger," and, perhaps, even of acidosis in varying degrees, may be features both of prolonged fever and physical fatigue; it might even be suggested that the tremors and prostration of the two conditions are analogous, and that subsultus tendinum may possibly represent a series of contractions dependent on the presence in excess of lactic acid in the muscles and circulating blood as the result of a too rapid katabolism due, in this case, to the fever.

Typhoid fever, perhaps more than most diseases, exhibits a tendency to affect muscle-tissue, but whether this is dependent on some influence of its toxins or the rapidity of its demand for fuel, or a combination of these influences, it is impossible to say.

IV.—Clinical Evidences.

Osler, the greatest living clinical authority on typhoid fever, says, "It is important to give carbohydrate freely to spare the body proteins, and this is aided by the addition of milk-sugar to the diet; a teaspoonful can be given with each feeding of milk. Sugar can also be given freely in lemonade." (The Principles and Practice of Medicine, Osler.)

The following observations were made on a series of cases of typhoid fever occurring among Belgian civilians and refugees in Flanders, and as the numbers were by no means small, and a large medical staff was employed, it was possible to make some rough comparisons of the various routines of treatment adopted. Unfortunately the observations were necessarily almost entirely clinical, but even in the absence of such scientific support as might have been rendered by the help of a chemical pathologist and more accurate tabulation of observations, it was considered that they might be worth publishing. It will be understood that when a number of British medical officers are dealing with Flemish-speaking patients under active service conditions, note-taking and the co-ordination of experiences cannot be expected to satisfy an enquirer into any particular branch of the work. When, further, it is taken into account that literature and references were only with difficulty obtainable, shortcomings and inaccuracies will, perhaps, be treated with leniency.

In a certain series of cases a diet containing a high sugar element in addition to other carbohydrate was given during the acute stages. Throughout the paper this is, for brevity, referred to as the *Sugar+* diet. In the majority of the remaining cases treated in this hospital the diet during the acute stage was stated as being "milk," "milk and soda," "fluids," "milk and meat extracts," etc. These are referred to as *Sugar—* diet. In the case of the children's ward the diet was usually "milk and large quantities of chocolate."

The more liberal (Sugar+) diet consisted, with slight variations for age and idiosyncrasies, of milk two-thirds pint, with the addition of bread three times a day, making bread-and-milk, biscuits (Marie), and chocolate (solid); barley-water was given freely, and cocoa occasionally as an extra.

To every feed of milk or bread-and-milk was added 1—2 tablespoonfuls of white granular cane sugar, the patient thus receiving from 6—8 ounces by weight of sugar in the twenty-four hours, and in later cases as much as eight or ten ounces, in addition to such sugar as the biscuits and chocolate contained.

Ten ounces of sugar represents about 1,000 calories. The full field service ration of sugar for a British soldier is three ounces per diem.

With a working digestion, cane sugar may be considered as equivalent to dextrose, and it was not deemed necessary to go to the expense or trouble of obtaining sugar in this form or as lactose. In the first instance this diet was adopted mainly with a view to averting, or to treating in some cases which were admitted late, the emaciation which takes place with such rapidity in typhoid fever; its cheapness and assimilability especially recommended ordinary cane sugar.

Typhoid fever is noted as being a disease which particularly affects muscle tissue. The general relaxation and helplessness, the incontinence, the meteorism, the dilated pupils, the occasional deafness, and the heart failure are all evidence of this. Its attack on the muscle fibre may, perhaps, be regarded as being twofold. It is in part a sustained direct attack with toxins, and in part an attrition process, eating up reserves and exhausting the fat and muscles of the body by excessive calorie consumption. In the absence of plenty of carbohydrate in the diet a very rapid exhaustion of tissue reserves is apt to occur, for in this event carbohydrates must be supplied by body-fat or body-protein.

The more obvious direct and indirect results claimed for a Sugar+ diet can be briefly summarised as follows:—

1. The general nutrition is not so seriously impaired; the disappearance of superficial fat and natural "pads" is largely avoided, with the result that bedsores and skin infections are less liable to occur. No cases could at any stage be described as really "wasted," in the Sugar+ series. In contradistinction, wasting was extremely marked in many cases admitted late or kept on other regimes of diet.

2. Stimulants are naturally less necessary. With the exception of brandy on a few occasions, and for short periods, and strychnine and digitalis in two exceptional instances, no stimulants were ever considered necessary among the patients of the Sugar+ series, although this included many very bad cases. Among those patients on a Sugar— diet, alcohol in various forms, strychnine and digitalis were extensively used.

3. Incidentally the employment of solids in the shape of bread, biscuits, and chocolate maintains the mouth in a much healthier state, partly by the mechanical removal of debris in mastication, and partly by causing an increased salivary flow. The testimony of ward-sisters fully supports this contention. But, in addition to these, there are other less apparent, but nevertheless suggestive evidences in favour of a Sugar+ diet.

Firstly, any tendency to acidosis is minimised by its employment. In this connection it may be recorded that two cases of definite acidosis presenting clinical symptoms occurred in this hospital. One was the case of a young woman in a relapse of typhoid fever associated with diphtheria, who developed incessant vomiting. The urine contained acetone and diacetic acid. There was no evidence of pregnancy and no glycosuria. The diet in the acute stage had been "fluids," and in the relapse "milk and soda." Symptoms were at once relieved by the administration of alkalies by the mouth and dextrose by the rectum. Of the second case no notes were to hand, but the urine confirmed the diagnosis.

A third case occurred in a child with mild cerebro-spinal meningitis of fourteen days' duration, who developed alarming air-hunger and a failing pulse after a brief administration of chloroform for purposes of

lumbar puncture. The diet had been milk only. The urine gave the ferric chloride reaction. Further, though they cannot be claimed as cases of acidosis, several cases in the children's ward had vomiting, and one died of vomiting for which no cause was found. Acidosis with or without vomiting is known to occur with great rapidity in febrile children. Unfortunately no routine investigation of the urine for acetone and diacetic acid was made. It is obvious that such a routine would be of value in the recognition and treatment of carbohydrate deficiency.

Experience here seems to show that typhoid patients may manifest a definite "sugar hunger." A heaped tablespoonful or more of cane sugar in every 8—10 ounce feed of milk would be found excessive by the normal individual, but among the male patients no complaint of this ration was ever made, and ward-sisters testify to the fact that patients were even to be seen scooping out the dregs of sugar from the bottoms of their cups. Boys of 16 and 18 sometimes cried for more chocolate. The women were unable to take such large quantities of sugar, and it is suggested that their possession of larger reserves of body-fat may, perhaps, provide an explanation of their smaller requirements.

A second observation, relative to the impairment of muscular function after typhoid fever, may have a further bearing on the question.

The statement that the body proteins, especially as represented by the muscles, are called upon to supply carbohydrate in typhoid fever, demands evidence other than that provided by theory and the occurrence of acetonuria. So far as the skeletal muscles are concerned, no clear evidence can be obtained, for the general lack of tone during the disease and the post-typhoid weakness might be accounted for in many ways. Changes in the function of plain and heart muscle, on the other hand, are more readily noted.

It was the custom in this hospital to chart the pulse rate as a red curve, the temperature as a black one, and nothing was more striking to the eye in a casual tour of the wards or tents than the marked lack of correlation between the red and black lines in a certain proportion of the convalescent cases.

Osler states that, "during convalescence the pulse gradually returns to normal and occasionally becomes very slow. After no other acute fever do we so frequently meet with bradycardia. I have counted the pulse as low as 30, and cases are on record of still fewer beats to the minute. Tachycardia, while less common, may be a very troublesome feature of convalescence." (The Principles and Practice of Medicine, Osler.)

In this series of cases tachycardia was at least twice as common as bradycardia, and neither manifestation appeared to be associated with any symptoms of physical signs of cardiac or other lesions. It was further noted that these manifestations seemed to be less frequent among those patients who were on a liberal carbohydrate (Sugar+) diet in the acute stages of their illness. Constipation is another very frequent and troublesome symptom of convalescence from typhoid fever. The medical officer in charge of the largest female ward here, where "fluid" diets were the routine in the acute stage, stated that "nearly all his patients were constipated in convalescence." The medical officer in charge of the children's ward made a very similar statement. Constipation did not appear to be so marked a feature of convalescence among male patients of all ages treated with the Sugar+ diet. It is tentatively suggested that these manifestations may represent changes in the function of heart and intestinal muscle dependent on "muscle exhaustion" in the acute stages of the disease, that, in fact, disturbances in pulse rate and a constipation due to inefficient peristalsis are clinical indicators of a previous insufficiency of the carbohydrate element in the diet. For various reasons, such as the absence of records of purgation, no reliable statistics in regard to the frequency of constipation in the different dietary groups could be obtained. It is of interest that some of the cases of tachycardia were definitely noted as having been also profoundly constipated, further suggesting the possibility of a single ætiology. It has been suggested that the constipating effect of cow's milk and the purgative effect of added sugars, especially noteworthy in the case of infants, should be taken into account, but as all patients were soon promoted to an ordinary full or light full diet in convalescence, these influences would scarcely obtain.

A numerical analysis of the cases of cardiac rate disturbances and the possible influence of dietary on their incidence was attempted, but after making the very numerous eliminations and corrections that were considered necessary, the total number of cases was reduced to 105 (although some 600 were reviewed), and it was deemed that the percentages were too misleading to merit publication.

The following are the standards and corrections which were found necessary :—

1. An average pulse rate of 100 per minute or over in an adult, and of 110 or over in a child, persisting for varying periods of from one to eight or ten weeks after defervescence, was regarded as tachycardia. There was thus necessarily excluded a large group of cases with a pulse rate frequently above normal. A pulse rate more than occasionally below 60 was regarded as bradycardia. Cases of 16 and over were regarded as adults. All below the age of 16 were included in the children's group.

2. Only cases treated in the hospital during an appreciable period—usually ten days or more—of the acute illness or during a relapse were included, thus eliminating cases of disturbed heart rate occurring in patients convalescent on admission and concerning whom no notes of treatment were available.

3. In all cases included, the diagnosis was confirmed by bacteriological methods, *e.g.*, Widal's test, blood culture, or the recovery of Eberth's bacillus from the urine, or rose-spots.

4. Cases of tachycardia in which there had been an association of diphtheria, and three cases in which there was evidence of a possible previous diphtheritic infection, were excluded.

5. Cases in which there was mention in the case sheet of a heart lesion were excluded.

6. High evening pulse rates had to be disregarded in a few instances as the patients had a long flight of stairs to climb immediately previous to the taking of the evening pulse.

7. Other factors in the treatment of the various groups (*i.e.*, Sugar+, Sugar—, and "milk and chocolate") were much the same. Possibly hydrotherapy was more extensively employed among the Sugar+ patients. A higher percentage of this series received treatment with vaccine.

With these reservations the figures were found to suggest the following conclusions :—

Firstly, in regard to the tachycardia of convalescence, that it occurred in about one-sixth to one-fifth of all cases (almost certainly a low estimate); that it was more frequent in children than in adults, and less frequent in Sugar+ children than in Sugar— children, the children on "milk and chocolate" taking an intermediate place. That although not supported by the percentages available, it also appeared to be less frequent in those *adults* who had been on a Sugar+ régime. Tachycardia usually started from defervescence, though sometimes from "getting up," and lasted for long periods. It was not uncommon for a young adult patient to be discharged as late as the eighth week of convalescence with a pulse rate of 110 or even 120 per minute, but otherwise well and uncomplaining. In some cases the tachycardia presented a gradually "ascending," in others a "descending," curve.

Secondly, in regard to bradycardia, the figures suggested that it occurred in about one-tenth of all cases; that it was most common in men (curiously all cases of this series were adult males); that its incidence was less in the Sugar+ series, since actually no cases occurred among Sugar+ patients. Bradycardia was found to date usually from defervescence and to last from one to three weeks.

Thirdly, in regard to undisturbed pulse rate, that apart from all considerations of treatment, women showed the highest proportion of cases. Possibly this may be correlated with their absence of marked "sugar hunger" and their possession of more abundant reserves of body fat.

A certain proportion of the children were noted as having had an irregular or intermittent pulse, "dropped beats," or functional systolic murmurs in the acute stages. Two of these were on a Sugar+ régime, and did not develop tachycardia in convalescence. Of two on other régimes, one developed tachycardia and one did not

Of seven cases of diphtheria in men and boys following, or associated with typhoid fever, and given a Sugar+ diet, none showed abnormalities of pulse rate in convalescence.

Summary.

As the result of these observations it is suggested:—

1. That typhoid fever, being a long, febrile disease with a consequently high calorie consumption, demands a high carbohydrate element in the diet. That the same may be held to apply to other febrile diseases in varying degree, particularly when they are of long duration.

2. That if this carbohydrate be not provided, the patient's body protein and fat are called upon to supply carbohydrate to the patient's disadvantage.

3. That acidosis (as evidenced by acetonuria) in the acute stages and possibly the disturbances in the function of heart muscle, causing tachycardia or bradycardia, and of the plain muscle of the intestine, causing constipation, in convalescence, may all prove to be indications of a deficiency in the amount of carbohydrate supplied.

4. That carbohydrate may be given freely and without fear, as suggested in the diet employed here. In no case were any ill effects traceable to this diet.

5. That cane sugar is the cheapest and simplest form in which to administer carbohydrate, and that it may be given in sufficient quantity to supply from 500 to 1,000 calories per diem.

Since writing these notes another case of acute typhoid, and seven out of eight cases admitted for scarlet fever, all in adult subjects, were found to give a marked ferric chloride reaction in the urine. It may be that the early vomiting in scarlatina is dependent on an acidosis. Bradycardia is also a frequent feature of scarlatina after defervescence.

Thanks are due to Mr. Ryffel and to various medical officers of the R.A.M.C. for assistance in the preparation of these notes.

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Papers by Guy's Men.

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Some Cases of Growth of the Upper Jaw and Ethmoidal Region.

CLINICAL DEMONSTRATION BY W. M. MOLLISON.

GENTLEMEN,—The following cases of growth involving the superior maxilla and ethmoid have been seen in the Throat Department in the last two years—three of them in the last fortnight. They are all women. Five are cases of carcinoma and two cases of sarcoma. Four of the cases of carcinoma are here for you to examine; two of these have been operated upon, and the others are awaiting operation.

Of the two cases of sarcoma, one was operated upon some months ago, and so far is free from recurrence, and one died a few weeks after operation with extensive recurrence.

The first case is that of Eliza C., aged 46. She attended in the Out-Patient Department in January, 1914, complaining of pain in the left side of the face, nasal obstruction, epistaxis and some swelling of the left cheek.

Six months previously she began to be troubled with attacks of epistaxis from the left nostril; four months previously she had a bad attack of "influenza," and was in an infirmary for three weeks, and at this time wasted conconsiderably; one month later she had eight teeth extracted, and since then swelling of the face has been noted, and the patient has had pain in the left temporal region.

On admission to the Hospital there was a slight swelling in front of the left maxilla, below the infraorbital foramen; this was very tender on pressure, there was complete left nasal obstruction, and the nasal septum was pushed across to the right side, causing some obstruction on that side also. There was a purulent nasal discharge and a soft polypoid mass in the middle turbinal region.

A piece of this mass was removed for microscopical examination, and Dr. Nicholson reported "an atypical squamous-celled carcinoma arranged in large alveoli and without any signs of keratinisation.

Dr. Shipway administered ether by intratracheal insufflation, and operation performed; Fergussons incisions were made with the modification that the incision was not carried through to the free margin of the lip; the soft tissues of the cheek were stripped from the bone and thrown downwards; it was then seen that the anterior antral wall was already perforated by growth which had infiltrated the cheek over a small area. The anterior antral wall and the nasal process of the maxilla were removed, and the growth which filled the antrum was stripped from the cavity (it did not appear to be invading the bone), the outer wall of the nose was removed completely with the ethmoidal cells, and the mesial portion of the orbital floor; deeply the sphenoidal air sinus was seen and found to contain pus; it was opened freely. During the operation bleeding was not severe. Finally the cavity was packed with sulphur and gauze and the flap replaced. Recovery was uneventful.

About seven weeks later the patient was again admitted for removal of the glands in the left side of the neck. On admission a gland could be felt in the carotid triangle. The operation was performed and all the glands removed, one gland was reported on by Dr. Nicholson: "one of the two large glands examined is infiltrated with new growth" (carcinoma).

You now see the patient 21 months after operation. She is well, and has put on weight, and except for a little pain about the inner part of the scar, is quite comfortable. There is no sign of recurrence of the growth either locally or in the neck. Also you will notice how very slight is the deformity of the face.

When one considers that the glands in the neck were already involved by growth the result of the case is most fortunate.

The second case is that of Florence B., aged 38. This patient attended the Hospital in June of this year, complaining of an ulcer in the palate and the right upper alveolus, and much pain. For about four weeks the patient has had swelling in the mouth on the right side, and recently has noticed a ulcer. She had some septic teeth which have been removed. There was an elastic swelling involving the alveolar process of the jaw in the region of the molar teeth, and in the palate a circular ulcer about one and a half centimetres in diameter; the floor was covered with vascular granulations. The right side of the nose was somewhat obstructed, but showed no evidence of growth; the right side of the naso-pharynx was a little pushed in perhaps. As the growth appeared to involve the lower part of the maxilla rather than the upper, access was gained by slitting the cheek and turning upwards a flap of soft tissues. On opening the antrum the growth was seen to be extending on the floor and back-

wards, but not upwards towards the ethmoid region. To get beyond the growth it was necessary to expose the pterygoid plate and remove part of the muscles attached. As a preliminary to the operation the external carotid was ligatured.

Unfortunately in this case recurrence has occurred rapidly, and as you see there is considerable swelling of the right side of the face, and the ulceration in the roof of the mouth is extensive and bleeds easily. As far as could be seen recurrence began in the deep part of the operation cavity, and in spite of two or three treatments by diathermy advanced rapidly; there is now a gland to be felt in the submaxillary region. The patient suffers considerable pain.

In this case the growth doubtless began in the alveolar margin, probably in the gum, perhaps in connection with the septic teeth; from there it invaded the antrum—a boring epithelioma so called.

The next case is Margaret M., aged 59, whom you see here. She attended in the out-patient department complaining of pain over the right side of the face, epistaxis and nasal obstruction: on account of the severity of the pain malignant disease was suspected. The antrum was punctured from the inferior meatus of the nose and washed out and a little pus found; it was noticed that the needle entered very easily. You will notice there is almost no swelling of the face, perhaps behind and below the malar prominence there is a slight fulness, the palate is normal. Nasal examination shows considerable obstruction, and some finger-like projections in the middle turbinal region with mucopurulent discharge. Under an anæsthetic a small piece of the middle turbinal was removed for examination, and was pronounced to be squamous-celled carcinoma by Dr. Nicholson. There is a right-sided otorrhœa.

Since demonstrating the case operation has been performed under intratracheal insufflation of ether. Fergusson's incision was used and the anterior antral wall removed as before; the growth was found filling the antrum, and extending upwards towards the ethmoid and involving some cells; all the ethmoidal cells were removed and the whole outer wall of the nose, also the inner half of the floor of the orbit which was invaded by growth; the sphenoidal sinus was found to be large and to contain pus; it was thoroughly opened. Finally sulphur was sprinkled into the cavity and a gauze packing inserted, and the incision sutured. Except for some redness along the incision, recovery has been uneventful, though slow. This case emphasises the importance of pain in connection with nasal obstruction and discharge, as a sign of growth rather than suppuration in the antrum.

The fourth case is that of Janet P., aged 74; you see she has a swelling on the right face; this she has noticed only for six weeks, her first symptom was epiphora; for three weeks there has been a yellow and blood-stained discharge from the right side of the nose. The swelling occupies the upper part of the cheek, the side of the nose, and the inner part of the lower orbital margin, displacing the eyelid upwards; it projects considerably and is tense on palpation, the skin over it is somewhat red but is nowhere adherent, the limits of the mass are not obvious except outwards where the edge is easily felt, raised two or three millimetres about the level of the orbital margin. There is complete nasal obstruction on the right side but no affection of the palate or nasopharynx.

The patient has never had a day's illness in her life except that twelve years ago she had operation for cataracts in both eyes.

Since the demonstration Dr. Shipway kindly saw the patient and decided that she was able to take an anæsthetic: operation was therefore performed under intratracheal insufflation of ether again.

Since the growth involved the ethmoidal region Moure's incision was used and the growth removed completely (?); it was found to fill the antrum, to involve the whole orbital plate which it had absorbed: the outer wall of the nose with the ethmoidal cells was all removed; the sphenoidal sinus again contained pus and was opened. The patient bore the operation very well though she required some saline injection on account of a considerable loss of blood: her recovery was rapid and she was up five days after operation: on account of the extensive removal of the orbital floor the eye has dropped somewhat.

This case is in marked contrast to the previous one in that there was an external swelling, but in both pain was a marked symptom.

The cases of sarcoma I cannot show you unfortunately but they may be quoted for comparison with the above.

(*a*). Violet H., aged 19, presented herself to a doctor in August, 1914, on account of proptosis of the left eye and headache in the left frontal region. Some teeth were extracted, but the symptoms persisted until the patient attended the Hospital in November; there was then marked proptosis forwards of the left

eyeball, swelling of the left cheek, and some thickening of the infraorbital margin. A radiogram showed the left antro-ethmoidal region to be opaque in comparison with the right side.

Dr. Nicholson reported that the growth was a chondro-sarcoma, from examination of a small piece removed from the nose. Operation was performed through Fergusson's incision, the growth removed from the antrum, the ethmoidal cells and osplanum were removed, and it was then found that the growth had invaded the back of the orbit so extensively that the eye had to be removed; this was done by Mr. Ormond, who was kindly assisting at the operation.

The patient recovered from the operation and was much more comfortable; but in a few weeks extensive recurrence took place, and she died.

(*b*). The second case of sarcoma was more fortunate. Nellie R., aged 19, attended the Hospital in December, 1914, on account of some swelling in the region of the nasal process of the maxilla on the right side. There was some right-sided nasal obstruction, due to pushing in of the outer nasal wall.

Examination of a piece removed from the middle turbinal region showed the growth to be sarcoma.

Operation was performed on January 1st, 1915. Moure's incision was made, the nasal process of the superior maxilla exposed, and the growth found springing from the anterior ethmoidal cells, and extending downwards into the antrum in a series of finger-like processes. The whole lateral mass of the ethmoid was removed, and part of the anterior antral wall.

The patient made a rapid recovery.

Seen again to-day, October 11th, ten months after operation, she is quite well and has no trace of recurrence, and the scar of the incision is very little noticeable.

There is one recent case of carcinoma to be added to those described; it is that of Anna B., aged 30. The patient attended the Hospital on October 12th, 1915, on account of a swelling of the right upper jaw. She had noticed this swelling for three months, and three weeks before coming to Hospital had been to her dentist, who removed some teeth and "lanced" the swelling, subsequently washing fluid through from the swelling into the nose.

The patient has a very depressed bridge to her nose and an earthy complexion, and there is little doubt that she is the subject of inherited syphilis. There is some swelling over the lower part of the right cheek and filling up of the region below the malar. On palpation in the mouth the swelling is found on the outer side of the alveolar process; it is smooth and elastic, giving the sensation as of a cyst. There were no teeth in the jaw; there are no glands to be felt in the neck. The patient was admitted and an incision made over the swelling through the mucous membrane, and a piece of the mass removed for examination; this incision showed that the swelling was not a cyst, and naked-eye examination was strongly suggestive of growth.

Dr. Nicholson reports squamous-celled carcinoma. This case presented features closely resembling a dental cyst. Operation has been performed again under the intratracheal insufflation of ether.

Operation performed on October 28th. Dr. Shipway again kindly administered ether by intratracheal insufflation. Fergusson's incisions were made, the lip being cut through completely; the cheek was turned outwards so far as to expose the anterior half-inch of the masseteric attachment to the malar bone; hæmorrhage was very free and gave rise to some difficulty and delay. The growth was found to have broken through the anterior antral wall; it filled the antrum and had destroyed the floor of the orbit and the bony palate, and had infiltrated the soft tissues of the palate, which were therefore removed. Deeply the infiltration did not appear to have overstepped the limit of the antral cavity except at the sphenoidal region, and here the appearance suggested invasion of the base of the skull. The Eustachian cushion appeared normal, and the posterior part of the soft palate was left *in situ*. The cheek was sutured in position, and the large cavity lightly packed with a pad through the mouth. On account of the loss of blood the patient was given saline during the operation.

Notes.—The two cases of sarcoma were in quite young patients, and in both the growth certainly began in the ethmoidal region, probably the anterior ethmoidal cells and spread secondarily to the antrum. The symptoms caused are due to expansion of the lateral mass of the ethmoid externally to the orbit, with consequent displacement of the globe, internally to the nose, with resulting nasal obstruction. In neither case was there any ulceration in the nose.

The cases of carcinoma occurred at very diverse ages, the youngest 30, the oldest 74. Excluding the case of boring epithelioma, which perhaps should not be included in the same class as the others, the carcinoma seemed to arise from the lining of the antrum, perhaps in

its inner part, and spread in all directions, particularly upwards and backwards. The cases demonstrate the importance of pain in conjunction with nasal obstruction as a sign of malignancy versus suppuration in the antrum; finally, the last case emphasises the close similarity between a cyst of dental origin and carcinoma.

As to the operation for removal of these growths, half the difficulty used to arise from the passage of blood to the larynx and the constant need of sponging to prevent this during the operation. Now no difficulty need be experienced at all from this cause. By the use of intratracheal insufflation of ether, blood is entirely prevented from entering the larynx, and the surgeon is able to concentrate on the operation without any anxiety. In all these cases Dr. Shipway kindly gave the anæsthetic by this method. The method has also the advantage of preventing exhaustion in the patient should the operation be prolonged, as it may well be should the growth be found to pass deeply.

Pneumonia in General Practice.

In the GAZETTE of September 26th last, I read with interest the notes on some cases of lobar pneumonia, and they brought to mind the fact that we very rarely see a case of "real" lobar pneumonia nowadays in general practice. Going back over the cases of pneumonia that I have treated in the last eighteen months, I can only find one straight forward case of this disease, and that occurred fifteen months ago. The patient was a fine healthy man of about 65 who had never known illness before. Well marked physical signs developed, and for the first thirty-six hours he did excellently, with every sign of satisfactory reaction; in the following twelve hours marked pneumococele septicæmia set in and he died. The septicæmia was intense and drugs were of no use, though stimulants were "pushed" in the hope of combating the cardiac failure.

The other cases formed a mixed collection, and though their mode of onset differed greatly, as did the physical signs and the course of the disease, they were nevertheless akin in that they were all of an insidious, shifty nature, and one could never foresee what course the disease would take.

Some of the cases followed influenza, and in these the first sign was usually a little patch of dry pleurisy over the part of the chest. Then a small and usually indefinite patch of pneumonia appeared in the region of the apex of the heart, or further out into the left axilla. This patch would clear up in a few days and other patches would appear on the right side of the chest in front, or on either side behind. This process continued for some weeks, and while the pneumonic areas were well marked, the temperature would keep between 100° and 102°, and, as they resolved, it would swing between 99° and 101°—usually lower in the morning—and there would be a more sustained rise as fresh patches appeared. Prespiration was excessive and the sputum varied, occasionally a little rusty, but mostly mucopurulent. Respiration 36-48.

The duration of the illness was generally about three weeks and the patients became very exhausted. The pulse rose early in the illness to from about 108 in adults to 120 upwards in children, and kept high throughout the illness and for some time afterwards. In fact, the heart was always severely affected by the disease and necessitated great after care. The pneumonia, too, appeared in spite of careful treatment of all influenzal patients, and was only one of the many complications that followed influenza, though our patients were rigorously kept to bed and dieted while the temperature was at all raised.

The amount of dry pleurisy over the front of the chest was very noticeable in these cases, and in one case of this type—though the pneumonia in this instance followed measles—there was pleuro-pericarditis.

The infection in these cases was of a mixed variety, and the patients had perhaps more of a septic than a pneumonic appearance.

The treatment adopted of course varied greatly, but certain lines were usually followed. Antiphlogistine was applied regularly and an expectorant mixture with nux vomica, varied with an effervescent mixture containing bromide were used. Quinine (gr. ij.) in suppositories per rectum, or in cachets by mouth, was given a thorough trial, but I was not convinced that it was of much use, though Dr. Morgan Hearnden, with whom I saw most of these cases, thinks it is of value if given by mouth in cachets. Brandy and other stimulants were used when necessary, and all of these cases recovered though the convalescence was very prolonged on account of the cardiac condition. No cardiac murmurs were heard in any of the cases, though there were about six cases of this sort.

The next type was one in which the onset resembled that of ordinary lobar pneumonia, but as the disease progressed the patients became very septic in appearance. The lung signs were that of pneumococele lobar pneumonia, and at first the disease appeared to be such. But after about three days there was a slight improvement, and then a severe relapse with intermittent temperature and cardiac failure The patient's face was usually very dusky in appearance, eyes sunken, hands moist and clammy. There was excessive and continuous perspiration which soaked the whole bed and necessitated very frequent change of clothing, etc. There was none of that flushed and over bright appearance of the face that one hoped to see. In fact, in the latter stages of the disease, the patient's appearance—except for the

character of the respirations—was that of one suffering from a general septicæmia, and not from pneumonia. These cases were very fatal, and all died within a week.

The last group of cases were those in old people who had for some time had more or less permanent œdema at the basis of the lungs before the onset of the disease. Of course, this type is very well known, but I only mention it to record two interesting facts that struck me after having several of these cases on my hands last winter.

The first fact was that the pneumonia in each instance did not appear to begin in the œdematous area, but usually above and distinct from this, though the two merged into one another, more or less, later in the illness. The other fact was that while the males did very well, very few of the females recovered.

All old practitioners with whom I have discussed pneumonia, agree that the old type of lobar pneumonia is, like the large families of our ancestors, becoming very rare.

Serbia.

IV.—THE TYPHUS EPIDEMIC. A BALKAN FLORENCE NIGHTINGALE.

. . For " when I give, I give with my two hands,"
You said, and your young voice, I know not how,
Seemed sweet with sorrow from unsaddened lands.
The Flute of Sardonyx. EDMUND JOHN.

The outbreak of typhus in Serbia, which began at the close of last year, and was only stamped out after it had ravaged the entire country for a period of six months, seems to have had its origin among the Austrian prisoners captured in the *debâcle* around Shabatz, which lasted from December 3rd—10th (O.S.). In this tremendous rout, whose magnitude can be gauged from the fact that the prisoners taken are variously estimated at 70,000 to 100,000, the extreme mobility of the Serbians in mountainous districts turned an apparent defeat into an overwhelming victory. The Austrian army, having forced the passage of the River Drina, pursued the retreating Serbians into the mountains. The troops employed by the former consisted, for the most part, of Bohemians and Moravians from the central plains, totally unused to mountain warfare, and furthermore burdened by the regulation pack of 33 kilos. The Serbs, on the other hand, carried nothing save their rifles, and had no transport service save a few quickfirers carried on muleback. Each man supplied his own commissariat, a little meal or goat-cheese and a few raisins, for years of privation and famine had made their powers of resistance phenomenal. The Austrians, having been lured into the mountains, and advancing with such rapidity that all their supply train was left far in the rear, were subjected to a withering machine gun and rifle fire from the summits, which, laden and already exhausted as they were, were totally inaccessible. For almost a week the slaughter continued, till harassed by guerilla attacks and on the verge of starvation, practically the whole remaining force surrendered unconditionally. The curious may read an account by an eye-witness of the field a week later in the *Times* of about January 15th; from the stories of prisoners and soldiers wounded in the fight one could piece together the details of a disaster almost unparalleled in the annals of the war. Suffice it to say that this marked the end of the Austrian offensive and had not our gallant little ally been stricken with a far deadlier scourge, there is no doubt that a successful invasion of the enemy country would have been carried out as soon as the headquarters' staff had had time to re-organise and re-equip their forces. As it was, hostilities were practically at a standstill for about five months, save for an occasional bombardment of Belgrade or frontier skirmish.

There seems, according to the prisoners' own accounts, to have been a little typhus among the Austrian troops as early as October, and it is probable that the germs of the disease were already present (though latent) among the invading force. But the determining cause of the epidemic is undoubtedly to be sought in the appalling conditions in which the prisoners were, perforce, housed and the lack of adequate food and sanitation, a very natural result of the sudden capture of such an overwhelming number of prisoners. Knowing the Serbs as I do, I should be the last to lay to their charge any accusation of callousness or indifference. To have made provision for such a number of men in a country already impoverished by three years of war would have been to achieve the impossible. Moreover, a total ignorance of the ordinary principles of hygiene, the lack of doctors and hospitals made the outbreak much more difficult to cope with once it had obtained a fair hold of the country, than it would have been in a community replete with the latest discoveries of medical science. With all these matters, however, I hope to deal more fully at a later stage. The epidemic commenced towards the end of December, its outbreak being almost simultaneous in half a dozen centres. The prisoners at this time were housed in barns, disused Turkish barracks, stables, and low-class cafés, in any spot almost that afforded shelter. So great was the scarcity of food that in many places it was possible only to provide them with a loaf every three days and a jug of water. Moreover, their numbers were so large that any effective control was impossible, and they were practically free to wander around the country, begging their food through the villages, and wandering in the towns soliciting money from the passers by. It is easy, then, to conceive how, once the epidemic was fairly started, it spread like a devastat-

ing wave throughout the entire countryside till by the month of February there was not a hamlet in the whole of Serbia that was not an active focus of disease. The disease was not a new one. In the Balkan war of 1912—13 there was a considerable epidemic, and in some parts of the country, so I was informed, it exists in a milder endemic form, similar to that designated in the United States—Bull's disease. But whereas these had been localised and controllable outbreaks, this epidemic scoured the land like a devastating wave. There is an interesting historic parallel to be found in the second book of Thucydides' "Peloponnesian War," which at the risk of being tedious I should like to quote at some length. The writer's accuracy of observation, and the close similarity between the symptoms and aggravating causes of the two epidemics should be noted.

"In the first days of summer," he begins, "the Lacedæmonians and their allies, with two-thirds of their forces as before, invaded Attica, under the command of Archidamus, son of Zeuxidamus, king of Lacedæmon, and sat down and laid waste the country. Not many days after their arrival in Attica the plague first began to show itself among the Athenians. It was said the disease had previously broken out in many places in the neighbourhood of Lemnos and elsewhere; but a pestilence of such extent and mortality was nowhere remembered. Neither were the physicians at first of any service, ignorant as they were of the proper way to treat it, but they died themselves the most thickly, as they visited the sick most often, nor did any human art succeed any better. . . It first began, it is said, in the parts of Ethiopia above Egypt, and thence descended into Egypt and Libia and into most of the king's country. Suddenly falling upon Athens, it first attacked the population in Piræus—which was the occasion of their saying the Peloponnesians had poisoned the reservoirs, there being as yet no wells there—and afterwards appeared in the upper city, when the deaths became much more frequent. All speculation as to its origin and its causes, if causes can be found adequate to so great a disturbance, I leave to other writers, whether lay or professional; for myself I shall simply set down its nature, and explain the symptoms by which it may, perhaps, be recognised by the student if it should ever break out again. This I can the better do, as I had the disease myself, and watched its operation in others.

That year, then, is admitted to have been otherwise unprecedented free from sickness, and such few cases as occurred all determined in this. As a rule, however, there was no ostensible cause; but people in good health were all of a sudden attacked by violent heats in the head, and redness and inflammation in the eyes, the inward parts such as the throat or tongue becoming bloody and emitting an unnatural and fœtid breath. These symptoms were followed by sneezing and hoarseness soon after which the pain attacked the chest and produced a hard cough. When it fixed in the stomach, it upset it; and discharges of bile of every kind named by physicians ensued, accompanied by very great distress. In most cases also an ineffectual retching followed producing violent spasms, which in some cases ceased soon after, in others much later. Externally the body was very hot to the touch, nor pale in appearance, but reddish, livid and breaking out into small pustules and ulcers. But internally it burned so that the patient could not bear to have on him clothing or linen, even of the very lightest description, or indeed to be otherwise than stark naked. What they would have liked best would have been to throw themselves into cold water, as indeed was done by some of the neglected sick, who plunged into the rain tanks in their agonies of unquenchable thirst; though it made no difference whether they drank little or much. Besides this the miserable feeling of never being able to rest did not cease to torment them. The body, meanwhile, did not waste away while the distemper was at its height, but held out to a marvel against its ravages; so that when they succumbed, as in most cases on the seventh or eighth day to the internal inflammation, they had still some strength in them. But if they passed this stage, and the disease extended further into the bowels, inducing a violent ulceration there accompanied by severe diarrhœa, this brought on a weakness which was generally fatal. For the disorder first settled in the head, ran its course from thence through the whole of the body, and even where it did not prove mortal it still left its mark on the extremities, for it settled in the privy parts, the fingers and on the toes, and many escaped with the loss of these, some too with that of their eyes. Others, again, were ceased with an entire loss of memory on their first recovery, and did not know themselves or their friends . . .

No remedy was found that could be used as specific; for what did good in one case did harm in another. Strong and weak constitutions proved equally incapable of resistance, all alike being swept away although dieted with the utmost precaution. By far the most terrible feature in the malady was the dejection which ensued when anyone felt himself attacked, for the despair into which they instantly fell took away their power of resistance, and left them a much easier prey to the disorder, besides which there was the awful spectacle of men dying like sheep, through having caught the infection nursing each other. This caused the greatest mortality . . . .

An aggravation of the existing calamity was the influx into the city from the country, and this was especially felt by the new arrivals. As there were no houses to receive them, they had to be lodged at the hot season of the year in stifling cabins, where the pestilence raged without restraint. The bodies of dying men lay upon one another, and half dead creatures reeled about the streets and gathered round all the fountains in their longing for water. The sacred places also in which they had quartered themselves were full of the corpses of persons that had died there, just as they were; for as

the disease passed all bounds, men not knowing what was to become of them, became utterly careless of everything whether sacred or profane."

No one who had ever seen a typhus patient could fail to recognize the accuracy of the description. The bloodshot eyes, the sudden onset of the malady, the fetid breath, and inflammation of the tongue and fauces, the rash, at first erythematous, but later breaking down into bloody sores, the intense depression, and utter indifference to surroundings, the inflammatory disturbances of the gut accompanied by diarrhœa; the Greek historian's account is like reading a page of Osler or Monro. So great is the craving for water that one of our patients threw himself into the Vardar; every night on the final trip made by the motor to the isolation hospital outside Skoplje, two or three poor wretches would be found staggering about in the final stages of delirium, or lying comotose in the water filled ditches. He notes too the characteristic odour, resembling damp straw, which no matter how clean the patients are kept, is always noticeable on entering a typhus ward. Nor less remarkable in both epidemics was the high rate of mortality amongst those who attended the sick, though as he goes on to observe, one attack gave immunity, an observation recently confirmed by the researches of Plotz, Olitsky, and Baehr.

The number of medical men in Serbia at the beginning of the war was 280, a figure which included dentists. By March no fewer than eighty of these had succumbed to typhus, and though the Greek government stepped into the breach and sent a number of medical men to assist the work, it was not till a party of 25 R.A.M.C. Officers under the command of Col. Hunter arrived from England, that effective measures could be taken to stamp out the epidemic. The sufferings of the Austrians and Serbian peasantry during this period cannot be conceived. Hospitals, properly speaking, were scarcely capable of accommodating a hundredth of the cases they were called upon to deal with. Buildings of every imaginable description were pressed to serve as hospitals, drugs, food, bed clothing, the simplest necessities of life, were virtually non-existent.

Thus, for example, I find in my diary an account of a hospital at Uzicé, near the Montenegrin frontier, where one lady doctor, an Austrian alienist and a dispenser had charge of 677 beds; in an infantry barracks in the same town out of 600 prisoners put there in December, 200 alone were alive by the beginning of March. In the height of the epidemic at Nish the mortality rose to 300 a day, in Skoplje where it was always more under control the death rate never exceeded 30, but nevertheless out of 5,000 prisoners only 900 were still alive after two months, The tale might be continued indefinitely, But there is little to be gained by a mere enumeration of horrors. The history of the outbreak is one of monstrous suffering and stoic endurance, Nothing fine or dashing, just working till you fell sick, and laying there till you died. Nursing your comrades while the pains grew on you and your limbs felt weaker and the agony of living worse to bear. And then the dull misery, the ugly ravings, the merciful end, So grim and hideous that existence itself seemed to have a tinge of the heroic. For heroism there was and of no mean kind amid the stench and degradation of those long, airless wards, packed to suffocation with the writhing green-grey forms, that turned pale, beseeching eyes to you, muttering and dribbling in their ragged beards, or lay still and apathetic in the coma that marked the end.

One scene, typical of a hundred others. A rigid figure, knotted in the anguish of a spasm, the face livid, a thin line of foam on the colourless lips, the neck tense and distorted, the wasted frame racked and quivering. By the pallet bed a homely wrinkled woman, clad in a gala dress with strings of bright beads and a gaudy yellow head kerchief, soothing, infinitely feminine; a little tear trickling down the furrowed cheek. For an instant the torn frame on the bed relaxes, and there is a passing glimpse of the man as he once was, a delicate beautiful face, high browed, fine sensitive nose, mouth full and sensuous, like the death mask of the poet Keats; then it vanishes as the agony resumes its sway. The figure by his side moves a little, smooths the filthy coverlet, moistens the lips with water. The *bollnitcha* motions me away, voluble, explanatory. He was once a professor of philosophy. Where? He does not know. Vienna? Perhaps. Unfortunately in his delirium he drank some sublimate from a bottle near his bed. Poisoned of course, no hope. A pity, poor fellow. And the woman? I ask. "Ah, she is brave;" for a moment a real enthusiasm gleams in his tired eyes. "When there was the fever in her own village she nursed them all, one by one they died, then, when she saw there was no more to be done there—all dead, you see—she came to us, asked if she could do something, no matter what, only to help. Just a peasant woman, you understand, no education, but her sons are dead and now, she says, she does not care, only to help the others, whose mothers, may be, cannot come. Ah, sir, all our women are like that!"

At Venatcha Banya, a Montenegrin girl named Marie Jankovic, studying medicine at Vienna, barely thirty years of age, has performed single-handed what I take to be one of the most remarkable works ever attempted by a woman. Installed there in June previous to the outbreak of the war, in charge of a hospital of 60 beds to deal with a local epidemic of enteric, she found herself at the commencement of hostilities entirely unaided, for all her assistants had been called under arms, and in the direct line of the wounded from the front on their way to the bases further South. Quickly her little hospital became filled with the more desperate cases, for whom a long journey would prove fatal. No help was to be had, the village was full of fever and some distance away. She set to work acting alternately as administrator, matron, surgeon, nurse, cook, and orderly. As the cases became convalescent they stayed for a little while to help her. Her own quarters consisted of a little curtained recess in one of the wards. Her food was that served out to the soldiers. For eight months she con-

tinued this almost superhuman task, nursing, dressing, cleaning, and it was only in February that an English unit came to her assistance, whilst, of course, leaving the direction of the hospital entirely in her hands. When the war is over she intends to complete her studies in England. No wide-spread recognition has been hers. For five months even her trifling stipend remained unpaid. Yet rarely, I think, has woman so deserved all the honour that courage and devotion can win. Asked once if she were never anxious for her future, she answered simply—"God is great, He will provide." The lamp of mercy shines as bright among the black crags of Montenegro as amid the snows of the Crimea.

G. H. F. G.

My First Anæsthetic.

Before—and After.

"BEFORE—AND AFTER" is not at first a very intelligible expression, but when it refers to the acquisition of those eight letters—usually called the "conjoint"—it not only becomes clear, but brings back vivid memories, recent or remote, of THAT night. when the "before" ended and the "after" began.

* * * * *

Normally the first anæsthetic one gives is administered in a theatre. in which every eye is fixed upon the unfortunate clerk—at least so he thinks.

In my case, however, the first was given while I was an extern. It was 2 a,m. in a typical Borough room, which, as usual, was almost filled by the typically enormous bed.

After the exciting preliminaries of obtaining the R.O., I commenced. The anæsthetic would persist in dropping at what appeared to me to be a racing speed, but with trembling knees and open mouth I kept on, clutching the small bottle with a grip which would have crushed any cocoanut of normal physique.

Through the semi-darkness I could just discern the shadowy form of the R.O. vainly trying to kick his feet, and at irregular intervals I was told to hang on at my end.

I wished heartily for a second pair of arms at these moments, but was quite unprepared for the abrupt termination of matters, which resulted in my head suddenly hitting the wall behind me, whilst the greatly respected "head doctor" staggered backwards and neatly sat on the glowing fire. However, "all's well that ends well," since we all "came round" at varying intervals, the R.O. being easily the first to recover his normal position.

* * * * *

Since that episode many months have passed, and many are the roofs that have sheltered me since I drifted away from the Hospital, but it was not until a short time ago that I gave the first anæsthetic away from the shadow of the tower of old Guy's.

This one was even more exciting, my nerves being somewhat over stimulated, as I had just had the doubtful pleasure of being hurled off the carrier of a motor bike.

A charitable friend had kindly offered to glve me a lift back to camp on the back of his racing $3\frac{1}{2}$ h.p. We were proceeding merrily through a thick fog some time after dark, when a light suddenly flashed under the front wheel: a sudden swerve, then a fearful crash, and I picked myself slowly out of the hedge to the chorus of "Nar yer've dun it!" from the unfortunate recipients of the combined weights of the machine and ourselves. This happened just outside the camp, and the next thing was a message to say I was wanted at once in the camp hospital.

Leaving the machine in the ditch, we hurried on and quickly arrived at the small inspection room. This was filled with a mass of struggling ffgures in khaki, which seemed to present an abnormal number of waving arms and legs. After sorting out men and furniture, I found that the source of trouble was an unfortunate Tommy in a very vigorous epileptic fit. The excessive zeal of the somewhat alcoholic members of the picket accounted for the earlier confusion.

The patient was a very bulky son of toil, and seemed to me to be at least seven feet long. After being jerked up and down rapidly for a few moments I succeded in plugging in I.M.H. gr. $\frac{1}{4}$.

After waiting some appreciable time and finding that the I.M.H. had no effect, and that it was practically impossible to get anything into patients mouth, I decided to try and quieten him with chloroform. This was far easier said than done, but after successfully soaking his hair and clothes I managed to get him quiet. A "breather" was thankfully indulged in, but our rest was very short as the patient came round and his foot caught me squarely in the middle of the back, hurling me on to my face to the great amusement of the picket.

I picked myself up and thoroughly "strafed" the patient with another dose of chloroform, and kept him just under for about half-an-hour. This time he was quite peaceful, and so I thankfully retired to my roost to anoint my bruises and enjoy the rest I felt I had earned.

V. E. L.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR,—We are now here again, having spent three months at Inladenovato, 30 miles south of Belgrade. We are running a hospital with about 100 beds—patients mostly old chronic cases, osteomyelitis, etc.

We have very few instruments here, and what we have are not of the best, yet we manage to get some very useful work done. I enclose reports of two of our operations, which are fairly typical. We are very hard at work, sometimes commencing to operate at 8.30 a.m., and

going on till 7 p.m., only stopping for meals—which are hardly worth stopping for.

Our food is provided by the army at 2s. per day per head, and is not all that could be desired. In our hospital here there are two surgeons, two dressers, and seven nurses in all. We have had a telegram telling us to be ready to move immediately, at a moment's notice, and there have been important movements of troops. We expect to go in a N.W. direction in a few days. The weather is still good, but how long it will remain like that is impossible to say, as I believe in October it is very wet and cold.—Yours sincerly,

VINCENT DREW,
Lieut. 2nd Army, Serbian Army.

Skoplje, Serbia,
4th October, 1915.

No. 18260. Sinuses in neck. Wounded 13 months ago. Two sinuses in neck ever since. Alleges was not shot at all, but only felt bayonet wound. Two previous operations, nothing removed.

Operation.—Two sinuses four inches apart, upper one at base of neck behind, one and a half inches from cervical spine, lower one four inches below this and three inches from spine. Probe passed deep into either sinus. five inch incision over and including both sinuses. Scapula cut down into. Spine of scapula splintered slightly and necrosed in parts.

First part.—Probe passed down lower sinus. Some sequestra discovered and removed. Ridge chiselled off all along spine of scapula as far as and including part of acromion process until healthy bone was reached. Counter incision two inches had to be made from original wound over acromion process in order to remove some loose pieces of bone in this region. Bone cleaned and sinus emptied and scraped.

Second part.—Upper sinus now explored, probe passed straight down for three inches on to bone. Another sinus discovered going down in vertical direction between body of scapula and ribs. Probe passed down distance of six inches; something felt loose at bottom of narrow sinus. After much difficulty, five pieces of bullet and many black sequestra were pulled out by means of forceps. This took a considerable time owing to number of fragments and narrowness and depth of sinus.

Finally.—Five bits of bullet (three large and two smaller), and 36 separate pieces of sequestra were extracted from this sinus alone. Sinus finally scraped. Wound thoroughly syringed out with hot water and sinuses packed with gauze. Wound partially closed with silkworm gut. In the evening patient very fit; no pain, no vomiting, and pulse good. Time taken, two and three-quarter hours. Chloroform used. Two days later wound looked very well, patient not feeling much pain. Every prospect of successful healing.

18245. Osteomyelitis tibia right. Post typhus (five months ago). Three previous operations. Wounded 13 month's ago. Large sinus just above internal malleolus. Probe passed straight down on to dead bone.

Operation.—Four inch incision down inner border of tibia over sinus straight down on to periosteum. Periosteum elevated. Large mass of dead bone at bottom of sinus. Hole as large as an egg chiselled out of bottom of shaft of tibia, only a shell of healthy bone left. Part of internal malleolus solt and rotten. Chiselled off. Hole right through lower end of tibia to other side of leg. Small counter incision to drain this. Hole thoroughly scraped. Syringed with hot water. Gauze drain passed completely through bone. Hole in tibia packed tight with gauze. Wound partially closed. One and a half hours chloroform.

Pass List.

Royal Colleges of Physicians of London and Surgeons of England.

At the Final Examination of the Conjoint Board held from October 5th to 19th, the following candidates were approved in the undermentioned subjects:—

Medicine.—E. S. Bowes, D. H. A. Galbraith, A. F. G. Guinness, V. R. Hirsch, J. G. Jones, W. G. S. Neely.

Surgery.—F. H. Edey, J. P. Jones. R. L. Portway, A. D. Vernon-Taylor.

Midwifery.—A. F. G. Guinness, V. R. Hirsch, W. G. S. Neeley, W. D Newland, J. G. Stevens.

At the Second Examination of the Conjoint Board in Anatomy and Physiology held in October, the following candidates were successful:—W. A. Flynn, W. H. Grace, D. V. Halstead, G. Meadows, F. W. Reitz, G. A. S. Shacklock, B. C. W. Simpson.

Royal College of Surgeons of England.

LICENCE IN DENTAL SURGERY.

At the First Examination, held in September, the following candidates were approved in the undermentioned subjects:—

Mechanical Dentistry.—D. W. S. Adams, C. A. D. Bishop, B. P. Cousins, H. Fox, P. E. Grobbelaar, J. C. Johnson, H. L. Jones, R. V. Kingham, F. R. Knowler, J. L. Lean, E. A. P. Parker, D. E. Robinson, E. F. Shaw, A. Weinberg, G. Wilshere, W. A. Woodward, C. C. Becker, R. L. Cowley, J. E. Fishburn, F. G. P. Flanders, I. J. Gardiner, H. O. Irwin, A. F. Percy, S. G. Townley.

Dental Metallurgy.—C. C. Becker, R. L. Cowley, J. E. Fishburn, F. G. P. Flanders, I. J. Gardiner, H. O. Irwin, E. W. Jarvis, A. F. Percy, S. G. Townley, W. R. Wotton.

The undermentioned diploma was conferred on the following candidates who have now complied with the necessary by-laws:—

L.D.S.—Louis Phillip Richards, Hedley Victor Stebbings.

Society of Apothecaries.

The Diploma of the Society was granted to J. B. Fairclough entitling him to practise in Medicine, Surgery, Midwifery.

Rugby Football.

A GUY'S XV. v. ROYAL NAVAL DIVISION
(Crystal Palace).

It was just like old times, with new actors, to have a Guy's team playing at Honor Oak Park again. Very few of the XV. of two years ago are now available. Kidman and Medlock being, perhaps, the only ones. Medlock has, as is well known, returned from France, where he has done much good service, to qualify, and has successfully done so.

It was a good clean game all through. With Guy's holding the visiting pack, Becker and Medlock had a fine time to half way through the game and their three-quarters were liberally fed, but only on two occasions did a score accrue, the try each time being gained by Knott, after Kendall had, with Medlock's assistance, cleared the way. However, for a first game for months and years, the whole side did very well. Medlock converted one of Knott's tries. Ends were changed, Guy's 8 points to nil.

Davies managed to get hurt soon after resuming, and with seven forwards the Naval men got going successfully, gaining a try by means of hard footwork. No goal resulted. Before Davies' departure he dropped a neat goal, and though Guy's were frequently very dangerous this was all the scoring till close on time. Medlock had Thomas going well on more than one occasion, but no try was forthcoming. Allen was pushed into touch just before the end, and from the *ensuing throw-out the ball was punted over to the left,* when Kendall and Knott got going, for the last named to gain his third try.

Mr. Allport very kindly refereed, and among our visitors was Sub-Lieut. Fraser who, some years ago, played for England and Richmond. He led the Naval men in most sporting fashion. There was a fair crowd, but many more spectators may be expected at subsequent matches, as Guy's supporters scarcely realise thus far that games are in prospect. Final score—Guy's (1 goal, 1 dropped goal, 2 tries) 15 points; R.N.D. (1 try) 3 points. Team :—

P. J. McEvedy (back); G. Allen, M. Thomas, N. E. Kendall, F. A. Knott (three-quarters); C. Becker, C. H. Medlock (halves); G. F. Kidman, A. W. A. Davies, D. M. P. Whitcombe, L. Gie, P. Reitz, C. W. Armstrong, L. Watson E. A. Leviseur (forwards).

A GUY'S XV. v. ROYAL NAVAL AIR SERVICE.
(Wood Lane).

In this, the second match of the season, the hospital team was far too strong for the opposition, and although most members of the team scored tries, while those that did not tried their form at place kicks, it could hardly be called an interesting game. The Naval men tried their hardest and were game to the bitter end, but failed to keep the score below Guy's (50 points) R.N.A.S. (3 points. Team :—

P. J. McEvedy (back); F. A. Knott, N. E. Kendall, E. A. Leviseur, — Blacklaws (three-quarters); C. Becker, C. H. Medlock (halves); G. F. Kidman, A. W. A. Davies, D. M. P. Whitcombe, C. W. W. Armstrong, L. Watson, P. Reitz, — Joffe, L. Gie (forwards).

Appointments.

Naval.

The following appointments have been notified:—Surgeons: C. G. Sprague to the *Thistle*, H. F. Percival to the *Tiger*, F. C. Newman to the *Commonwealth*.

Royal Army Medical Corps.

The undermentioned Captains to be Majors:—G. B. F. Churchill, H. D. M. Beadnell, R. P. Lewis, G. H. Rees.

To be temporary Captain:—A. H. Carter.

To be temporary Lieutenants:—H. W. Pigeon, E. G. Evans, R. Felton, F. G. Hopkins, B. C. Scott, J. E. Prentis, J. Braithwaite, H. Davies-Colley, E. F. Milton.

Home Counties Field Ambulance:—Capt. W. E. Alston to be temporary Major.

3/4 London Field Ambulance:—W. M. Langdon, M.R.C.S., L.R.C.P., of "Hillside," North Tawton, N. Devon, has been gazetted Lieutenant.

Attached to other than Medical Units.

Lieuts. G. B. Pearson and G. W. C. Hollist to be Captains.

Roll of Honour.

WOUNDED.

Capt. T. E. Roberts, attached to the 1st Batt. Lovat's Scouts.

Change of Address.

A. J. K. Drew, Esq., Royal Surrey County Hospital, Guildford, Surrey.

C. M. Anthony, Esq., 176, Lambeth Terrace, Lambeth, S.E.

A. P. Piggott, Esq., St. James's Infirmary, Ouseley Road, Balham, S.W., from Kesteven County Asylum.

H. Gardner, Esq., from 60, Rotherwick Road, N.W., to 1, Turner's Wood, Wild Wood Road, Hampstead Garden Suburb, N.W.

Major R. W. Murray, R.A.M.C., R.A.M.C. Mess, Fazakerley, Liverpool.

Lieut. Harold Webb, R.A.M.C., attached to 1st Battalion Suffolk Regiment, 28th Division. P.O.. 25th General Hospital.

G. S. Miller, R.A.M.C., from 24th General Hospital, No. 1 Field Ambulance, B.E.F.

Lieut. F. J. Wheeler, R.A.M.C., 2nd Hampshire Regiment, 88th Brigade, 29th Division, Mediterranean Expeditionary Force.

Capt. J. J. Conybeare, 4th Battalion Oxford and Bucks, 48th Division, B.E,F.

(The Editor will be very glad to receive a post card with notes of any change of address.)

Birth.

YOUNG.—On the 16th October, to Capt. W. A. Young, R.A.M.C., and Mrs. Young, a daughter.

E. N. G.

GUY'S HOSPITAL GAZETTE.

VOL. XXIX., No. 714.] NOVEMBER 20, 1915. [SIXPENCE.

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Passim.

AGAIN we have to produce our GAZETTE without the guiding hand of our Editor, who we regret to hear is marooned or otherwise detained at Malta. May his early return soon rescue the responsibilities from the support on which they now so insecurely lean, and relieve the anxiety of those who await answers and comments on the many burning questions which the editorial letter-box has of late contained.

CERTAINLY much attention is centred on the recent meetings and discussions in relation to Lord Derby's scheme and the young medical, both qualified and unqualified, but the news to hand is still so lacking in official confirmation that, beyond the announcement published by request in later pages, we feel it necessary to refrain from further mention of the matter.

COMING as a welcome cloud before the intensity of this much-vexed question, we see —and indeed often hear—the preparations for approaching Christmas. The festivities will be, as we understand, of the same restricted type as last year, but would especially point out that the Niggers are still an active force, and in view of the pleasure and diversion they provide for the patients and Staff alike, are more than deserving of all the support and time which the members can spare towards their development and perfection.

WE have been asked by the Secretary of the Students' Club to request that all suggestions —*or complaints*—relating to the existing service and catering in the College dining-hall should be addressed to the Secretary of the College Catering Sub-Committee, A. Magill, and signed in full by the sender. It comes to our notice that of late much adverse criticism of existing conditions has been heard—particularly at the Residents' table—and, to us, it seems only reasonable that the quality and the cooking of the food should attain at least a more appetising standard than has been seen for the past few weeks. We appreciate the difficulty of catering for a small and sometimes irregular number of men, but this is not an excuse in the case of the Residents and other house officials who must of necessity attend regularly, and for whom we consider it essential that a dinner of good quality and with even occasional variety should be provided. We would urge the various sections of the men whom this matter concerns to place their views, in writing, at the disposal of the Secretary, so that the desired improvement may be brought about as quickly as possible.

WE sincerely sympathize with Dr. Nicholson in his temporary disablement from burns received at the recent fire in his room. His laboratory attendant was also burnt, but owing to Dr. Nicholson's timely assistance, the boy's injuries are less serious than they might otherwise have been. We wish them both a speedy recovery.

THERE is now on view in the museum a relic of the last London air raid in the form of a piece of shell casing which, after bouncing on the roof of the surgical block, was picked up outside the doors of the Superintendent's Office.

We express our appreciation of the finder's kindness in handing the souvenir to the authorities.

WE read, with regret, the name of Capt. F. V. Bevan Brown, in the list of wounded among Expeditionary Forces. We have heard no definite news as to the nature of the injuries, but trust they are not serious.

WE are asked by several of the house officers to extend, through the medium of these pages, an impartial invitation to those unfortunates whose night duties do not take them further than the surgical block, where the no-treating order is being so rigidly enforced.

OUR sympathy goes out to the hard-worked officers in the out-patient departments in their efforts to cope with surging masses of the Borough sick, and we hope their unqualified assistants will pause a moment to consider the many small but essential ways in which they can assist in this all-important work.

"The President of the General Medical Council is requested by the Council to inform the Licensing Bodies, Medical Schools, and approved Teaching Institutions that the Director-General of the Army Medical Service has intimated to the Council his entire agreement with the Earl of Derby's decision regarding the recruiting of medical students, namely that:—

"'It is the duty of medical students (other than those in the fourth and fifth years of study) to join His Majesty's Forces.'"

"The President hopes that in every Medical School steps will be taken to convey this information to the students who are eligible for military service."

THE following Resolution was passed by the Staffs of Guy's Hospital Medical and Dental Schools at a Meeting held on November 9th.

> "The Staffs of the Medical and Dental Schools of Guy's Hospital are of opinion that all Schools should endeavour to facilitate the recently expressed official wish that Students in their First, Second and Third Years should place themselves at the disposal of the Military Authorities.
>
> "In view, however, of the national necessity of a constant influx of newly qualified Medical and Dental Practitioners for the services of the Navy and Army, the Staffs recommend that representations be made to the Government that Students after enrolment should be required to pursue their technical studies until otherwise instructed by the Admiralty or the War Office.

A letter has been sent by Mr. Cosmo Bonsor, President of the Hospital and Chairman of the Medical School, to Lord Derby, Director General of Recruiting, and copies have been sent to the Prime Minister and other authorities specially interested, informing them accordingly. The letter further makes suggestions as to the manner in which effect could best be given to the Resolution. The points brought out in the letter are as follows:—

1. To prevent in the near future a serious deficiency of Medical and Dental Practitioners, for the needs of the Naval and Military Forces as well as of the Civil population, immediate action is necessary.

2. The recent pronouncement, that it is the duty of Medical Students, other than those in their fourth and fifth years of study, to join His Majesty's Forces, is causing a considerable number, not only of the junior Students but also those of the senior years, to announce their intention of seeking commissions or enlisting in a combatant capacity.

3. While freely admitting that in the present circumstances all students who are medically fit should be encouraged to place themselves unreservedly at the disposal of the Government, it is advisable to ensure that those who have already embarked on a long course, which demands a continuity of study, should not be lost to the Nation as prospective practitioners unless it is an absolute necessity.

4. To facilitate this aim arrangements should be made whereby all Students who can obtain a certificate of industrious work in their Schools, and of satisfactory physical health, might be enrolled as "Cadets" of the Naval and Army Medical Services. Such "Cadets" would be placed under discipline and control; and in case of unsatisfactory conduct, or want of progress in their studies, would be liable to discharge, and would then revert to the "unstarred" class.

5. These "Cadets" should be so trained at the Medical Schools in First Aid and Minor Surgery as to be available for service in the case of emergency.

6. The allocation of these men after qualification, either to immediate Temporary Commissions in the Medical Service of the Fighting Forces or for temporary duty in Civilian Service, should be vested in some Joint Board of the Admiralty and War Office, acting, perhaps, in conjunction with other Government Departments interested in questions of health.

This Joint Board might, in consultation with the Authorities of the Universities and Schools, consider the admission of new Medical and Dental Students with a view to encouragement or restriction as to numbers, in accordance with the necessities of the situation.

7. Such a scheme need not involve the State in any financial liability. Students, if thus enrolled, would be willing to provide their own uniforms.

8. The details of such a scheme as is here foreshadowed can easily be worked out and all difficulties overcome by a conference of those interested.

Change of Address.

Lieutenant V. Drew, c/o Colonel Beavis, 1st British Field Hospital for Serbia. Headquarters, 2nd Serbian Armée, Serbia.

F. H. Fuller, Esq., M.R.C.S., L.R.C.P., L.D.S. Eng., of Linda, Poole Road, Bournemouth. Private address, from The Bungalow, Studland Road, to The Croft, Broadstone, Dorset.

L. S. Pilbeam, Esq., L.D.S., Litten Hotel, Newbury, Berks.

Lieut. J. H. E. Winston, 162, North Marine Road, Scarborough.

F. Collar, Esq., M.R.C.S., L.R.C.P., from c/o P.M.O., Nairobi, British East Africa, to West Coker, Yeovil, Somerset.

B. Rayne Parmiter, Esq.; M.B.; B.S., Lieut. R.A.M.C., from 15th General Hospital, Mediterranean Expeditionary Force, to 32nd Field Ambulance, 10th Division, Mediterranean Expeditionary Force.

Capt. H. F. Joynt, R.A.M.C., R.A.M.C. Mess, No. 2 Camp. Sling, Salisbury.

Lieut. F. J. Wheeler, R.A.M.C., 2nd Hampshire Regiment, 88th Brigade, 29th Division, Mediterranean Expeditionary Force.

Harold Webb, Lieut. R.A.M.C., from P.O. 25 General Hospital, to attached 1st Battalion Suffolk Regiment, 28th Division.

Harry Lee, F.R.C.S., Captain R.A.M.C. (T.), 1/1st West Riding Field Ambulance, 49th (West Riding Division) British Expeditionary Force, France.

Capt. J. H. Donnell, R.A.M.C. (T.), attached to 5th King's (Liverpool) Regiment, B.E.F., France.

Capt. B. H. Wedd, R.A.M.C., 23rd Field Ambulance, B.E.F., France.

Captain K. G. Davies, R.A.M.C., 3rd Battalion, The King's Regiment, Lhanion Barracks, Pembroke Dock.

G. Black, Esq., M.B., from The Gables, Hailsham, Sussex, to Norton House, Hurstpierpoint, Hassocks.

Monsters.

By G. W. NICHOLSON.

Congenital malformations, from a simple hare lip to a double-headed monster, when viewed as a class, do not receive the attention they deserve. Only a few of the minor ones have any clinical importance. They are therefore treated in a most superficial way in most text books. That of Adami is the only generally read one in which a rational classification of them is attempted. They possess a nomenclature which is not easily remembered. Most men, therefore, do not pursue their investigations into this subject much beyond remembering that monsters occur. This was very much the state of my own knowledge until recently, when I had occasion to examine the specimens in the museum. As I found these monsters to be by no means uninteresting or difficult to understand, it may serve a useful purpose if I give a broad account of the commoner and more important varieties, and add such theoretical considerations as may be necessary to an understanding of the subject. My summary will be very incomplete, and I shall not even attempt to touch many of the forms, especially those that may have been produced by a fœtal infection, but intend to limit myself strictly to the so-called "vices of development."

Now monsters, in their widest sense, if we call any error of development a monster, fall fairly naturally into two main groups; 1, such as are due to some error of development of a single individual; 2, such as appear to be caused by an arrest of development of one of a pair of twins, or by an abnormal union of two originally distinct individuals. Let us take the former group first:—

I. SINGLE MONSTERS.

Here we have either a deficiency or an excess of the normal degree of development. I do not propose to treat of dwarfism or gigantism, but will begin my review of the subject with a consideration of defective or arrested development of various parts. The order in which I shall take them is quite arbitrary. I shall not attempt to classify them according to the only truly scientific method, namely, the latest period of embryonic life at which they may be taken to have occurred, since that presupposes a degree of knowledge of embryology which I myself certainly do not possess, and which I may presume most of my readers to be equally devoid of.

(a) *Defective closure of fissures.*—Let us first consider the head. Here we may have a median fissure, which may divide the nose, both the jaws, the tongue, and may even extend into the thorax. Such conditions are very rare and are not represented in our museum. Very much commoner are the defects known as lateral hare lip and cleft palate. They may be bi- or unilateral, and are due to non-union of the fronto-nasal with the maxillary processes, and of the premaxillary with the maxillary bones. Branchial cysts are formed as the

result of incomplete obliteration of the branchial clefts of the embryo. They occur on the sides of the neck, and may be lined by squamous or columnar epithelium.

In the region of the trunk we may get a complete median anterior fissure extending from the chest to the external genitalia. If the process of closure has been arrested at a later stage, the fissure will be limited to the neighbourhood of the umbilicus. Or the closure may have been irregular, so that we may have a fissura sterni or an ectopia vesicæ by itself. Such a defect, if large, is always associated with a condition of hernia or ectopia of one or more viscera. There often is a tendency for more than one fissure to remain open. The museum contains examples of hare lip and cleft palate associated with extensive ectopia viscerum.

I may here mention the omphalo-mesenteric duct, the fœtal end of which may persist as Meckel's diverticulum. Or, again, the whole of the duct, with the exception of a small island in the region of the umbilicus, may disappear. This island then gives rise to the so-called umbilical polyp, a granular patch which is occasionally seen in young persons, and possesses the histological structure of intestinal mucous membrane (Meckel's diverticulum occurs about three feet above the ileo-cœcal valve. It should not be confounded with traction diverticula, which may occur along the greater part of the small intestine, and at the apex of which an accessory pancreas can often be demonstrated).

The next group I will consider consists of the monsters that are produced by a deficiency in the axis of the body at either of its ends. The parts that are missing can be represented as it were by a double wedge which has been cut out of the body. One side of this wedge will correspond to the mid-sagittal line of the body, its base will represent the superficial parts that are missing, and its apex will always lie at a point in the mid-sagittal plane in the interior of the body. The two wedges I postulate are always equal in size, and their median or sagittal sides are always in apposition. The remaining parts, after the wedges have been removed, may be assumed to have been accurately apposed and stuck together.

(*b*) *Cyclops.*—Numerous defects may occur in the face. It may be completely or partially absent owing to non-development of one or more of the branchial arches. The commonest malformation of this kind is that known as Cyclops. Here the bases of our wedges are formed by the parts in the region of the forehead, nose, and eyes, and its apices are situated at some point in the sagittal plane in the region of the basi-sphenoid. The resulting deformity will be an absence of a greater or lesser piece of the middle of the face and of the underlying parts of the skull. The eyes show all stages of fusion from two complete eyes which are in close apposition, to a double eye with two pupils, a broad eye with a transverse pupil, or no eye at all. The eyes always occupy a single orbit, which is, of course, situated in the anterior middle line. The nose, which assumes the shape of a fleshy proboscis, lies above the orbit. The mouth is small and circular. The ears lie low down and may, in extreme cases, be fused in the anterior middle line. The facial bones are more or less absent. The frontal fossæ are narrowed or fused, and the frontal lobes of the brain are small.

(*c*) *Sympus or Siren.*—If we assume our wedges to have been cut out of the hinder end of the axis of the body, we get the following deformities. The sacrum is short and narrow. The innominate bones are poorly developed. Owing to the smallness of the sacrum they tend to fall backwards and to become fused in the middle line behind and below it. The acetabula and with them the femora are therefore rotated outwards to such an extent that the latter become fused to each other along their external surfaces. The lower down we go, the more complete is usually the fusion and absence of parts. Owing to the great rotation of the femora the concavity of the knee looks forwards, the patella lies behind, the tibia or fused tibiæ (except in very slight cases the fibulæ are absent) point forwards, and the limb ends in a more or less perfect double foot or compound foot, whose heel and sole look forwards, and which ends in a variable number of toes, from ten downwards. The external genitalia are absent, and there is no anus, the intestinal canal ending blindly below. Often the distal parts of the tibiæ are absent, and the limb ends in a conical stump.

It is worthy of note that one limb only may be affected in this way, the other being normally developed. In such cases only one of our wedges has been removed from one side only of the sacral region.

(d) *Spina bifida.*—Spina bifida is the result of dropsy of the spinal cord. Over an area of greater or lesser extent the neural arches remain open behind. The laminæ and spinous processes are usually well formed, but the latter do not unite in the middle line. In marked cases they assume a position parallel to the transverse processes, so that the vertebræ appear to be broadened. The tissues behind the vertebræ are absent. A tumour is thus produced which consists of the skin, the spinal membranes, and the substance of the cord. It is often cystic and projects backwards. In such cases there is usually a large amount of congestion, so that we get a sessile of pedunculated purple mass over the lower part of the back of the child. In other cases it does not rise above the surface, and is then of a grey or pinkish semitranslucent appearance. When the cord is attached to the back of such a cyst, the spinal nerves run forwards through its cavity to enter the spinal foramina.

Spina bifida by itself is almost entirely limited to the lumbo-sacral region. It also occurs in the neck, but is then always associated with grave defects of the skull. If dropsy occurs at a later period of intra-uterine life, it gives rise to a cyst on the vertex or in the occipital region, known as encephalocœle. If it occurs still later, a condition of hydrocephalus is produced.

(*e*) *Anencephalus.*—Anencephaly is a defect in the roof of the skull, owing to which the brain is exposed and becomes continuous with the skin at its edges. It is very variable in extent. In mild cases the bones that are affected are the supra-occipitals, the parietals,

and the frontals. A large opening is thus produced on the top of the skull, which resembles a big fontanelle. There is, however, no membrane over it. The exoccipitals are never absent, but in extreme cases they assume a lateral position, thus allowing the defect to communicate freely with the foramen magnum. In marked cases the whole of the frontals, with the exception of the orbital plates, may be absent. The cranial vault is often depressed, and comes to lie immediately on the top of the base of the skull, the cranial cavity being almost obliterated. The eyes have a bulging appearance, and there is, of course, no forehead above them. The brain is reduced to a fibrovascular membrane, in which there may only be traces of nervous substance. It usually forms a rounded projection over the defect, and is filled with cerebrospinal fluid, or may not be raised above the surface of the surrounding integument.

Except in mild cases there is always a certain degree of cervical spina bifida as well. The vertebræ remain open behind. This condition may extend along the whole of the spinal canal. Cases in which it occurs are known as iniencephalous monsters. In them the vertebral column, as a whole, is very short. The shortening is especially marked in the cervical region, so that there is practically no neck, and the head is pulled backwards.

The cause of anencephaly is somewhat obscure, and has been often debated. It appears that most cases are due to dropsy of the brain. The pressure thus produced, together with the consequent interference with the circulation, and malnutrition of the parts, give rise to the characteristic deformity. Some cases, however, must be explained by external pressure and traction as the result of intrauterine adhesions. There are two specimans that illustrate this in the museum. In one of these the posterior part of the cerebroid tumour adheres to the fœtal surface of the placenta. In the other an intrauterine band is attached to the left elbow. In both there is enormous distortion of the face with twisting of the spinal cord. These two specimens differ in this respect from all the others. The amount and the irregular appearance of the disfigurement must have been caused by external violence, and cannot possibly be explained by a collection of fluid covered merely by a thin-walled cyst, which would infallibly have burst long before producing such results.

In anencephaly the suprarenals are frequently, although by no means always, reduced in size or absent.

(*f*) *Cystic Kidneys.*—This is the last condition produced by an arrest of development that I shall discuss. The kidney is developed in two parts. A bud grows forwards from the lower end of the Wolffian duct, which eventually forms the ureter, the renal pelvis, and the collecting tubules. This bud becomes applied to a part of the mesoblast lining the cœlomic cavity. From the latter the remainder of the kidney is developed. The glomeruli and the tubules, as far as and including the junctional tubules, are, therefore, mesoblastic in origin; the collecting tubules come from the Wolffian duct. It therefore follows that a union must normally occur between the junctional and the collecting tubules. If this union does not take place, the secreting tubules end blindly and become distended into cysts as a result of the accumulation of their secretion. Cystic kidneys are thus produced.

Occasionally areas of the mesoblastic part of the kidney are arrested at a very early stage of development, long before the tubules have been fully formed. Such areas are extremely rarely met with in man, although they are fairly common in ruminants. In man, however, they show a great tendency to assume an independent and malignant form of growth, and give rise to the "embryonic tumours" of the kidney, which consist of a matrix of round cells, whose character is sarcomatous, in which tubules in all stages of formation and differentiation are to be seen. They usually occur in children, in whom they are practically the only form of new growth of the kidney that is found, and are chiefly famous for the fact that they are constantly and persistently misnamed; sarcoma or hypernephroma being the usual term applied to them, whereas in reality they form a class by themselves.

(*g*) *Dichotomy.*—We now come to the errors of excess of development, and will briefly consider such as are produced by a duplication of the axis of the body at either or both ends, or along its whole extent. If the superior end of the axis is double, an Anadidymus results; if the inferior, a Katadidymus is produced. If both ends are double, we get an Anakatadidymus.

I will limit myself to superior dichotomy, as the other forms can be explained on the same principles. Here the axis is bifurcate at its upper extremity. A typical example, such as can be seen in the museum, possesses one pair of legs, and a breech of normal breadth. As we trace it upwards, the body gradually widens, owing to the fact that the spinal column has divided. The two spines are placed side by side, but they diverge laterally from each other, and at the upper end of the specimen we get two heads, and either two, four, or three upper limbs. In the last case the third or middle limb consists of the fused left arm of the right half and right arm of the left half of the monster. At the same time some of the soft parts will be either completely or partially doubled. For example, the specimen in the museum which has been dissected possesses single abdominal viscera. There is only one pair of lungs, but there are two hearts, which are fused by their adjacent auricles. There are also two aortæ, which give off branches to the corresponding heads. In this specimen the dichotomy of the spine ends in the sacral region, so that there is very little doubling of the soft

parts as compared with that of the axis. This is characteristic of this form of monstrosity.

We may, of course, have all grades of dichotomy. In the slightest of all the hypophysis cerebri only is double. A more marked case has a double face, and so on.

Now, although specimens like those in the museum present no difficulty, and are obviously caused by the splitting of a single individual, there are others that I must mention, which are not so easily explained. In them the whole of the spinal column is double. Many observers regard them as being due to the fusion of two originally distinct individuals. But in man, as Adami points out, the inferior growing point or pole of the body is not situated at the end of the tail region, but in front of this in the region of the anus. Again, by tying a thread round the egg of fishes and by other experimental means, all stages, from a slight dichotomy to two complete and independent individuals, have been produced. It stands to reason that it is possible for the splitting of the axis to have occurred at so early a stage and to have been so complete that two separate individuals may result. But this does not affect what will happen if the splitting has not been quite so complete. Even if the vertebral column is entirely double, so long as we can show that at any one point, though it be only at the extreme end, there is a single axis, I believe that the rational view to take is that these monsters have been formed by division of one individual, and not by the fusion of two.

II. DOUBLE MONSTERS.

(*a*) *Twins.*—Although twins are not in themselves monstrous, they are very closely related to the double monsters, and must, therefore, be briefly considered.

Twins may arise from two independent ova (dichorial twins); or from a single ovum which has at the first fission, completely divided into two halves. or from two embryonic areas which have appeared on the same ovum (monochorial twins). In the latter case, although their amnia are distinct, they are always surrounded by a common chorion and their placentæ are usually fused. Such monochorial twins may be equal if they have both reached the same degree of development, or unequal if from any cause the development of one be retarded. It is thus not very uncommon to get a full time healthy living fœtus together with another whose size and general development correspond to a much earlier stage. The latter is usually misshapen, and may be squashed flat from the pressure exerted by its healthy brother. In such cases all the bloodvessels on the placenta belong to the bigger fœtus.

(*b*) *Fœtus acardiacus.*—Sometimes the healthy twin at birth is accompanied by a shapeless mass of flesh, which is enclosed in the same chorion. This is an acardiacus. Although it may be quite formless externally, it possesses a vertebral column, and usually the rudiments of limbs. Often it takes the shape of half a fœtus, whose lower limbs are more or less perfect, but which ends abruptly above the umbilicus. Its skin is œdematous, and it possesses external genitalia and an anus. The intestinal canal ends blindly above. The kidneys are present. The thorax is usually not represented. There is no trace of a heart. This absence of the heart is the most characteristic feature of this condition, and gives us a clue as to its ætiology. If its umbilical cord be traced towards the placenta, it is found that its vessels come off from those of its brother either directly, or through their branches on the placenta. It has, in other words, no placental circulation of its own, but is parasitic on the other twin. This state of affairs has been brought about in the following way. One of the twins was weaker than the other, or had some deformity which placed it at a disadvantage. The more vigorous twin, A, therefore, grew more rapidly, and its bloodvessels on the placenta overgrew those of the weaker one, B. The only way that B was able to survive was through the formation of anastomoses of the branches of its umbilical artery with those of A. A, therefore drove his blood through the umbilical artery of B into the body of the latter, whose circulation was, therefore, reversed. For this reason the heart of B did not develop, and, as its blood supply was venous, such parts of it as did develop, become very œdematous and more or less imperfect.

In extremely rare cases the head end only of the acardiacus is formed (Acormus).

(*c*) *Cephalothoracopagus.*—It will be most convenient to study this form of monster next. It consists of two individuals which are fused in front from vertex to umbilicus. Let us imagine two fœtuses, A and B, each of which has been laid open by a line in the sagittal plane, which extends from the vertex to the umbilicus and reaches backwards as far as the spine. The two sides of this incision have been separated so that each is rotated through an angle of 90 degrees, and then A and B have been stuck together. The result corresponds to the Cephalothoracopagus. Here we have a monstor whose upper part can be represented by a rectangle. Its two lateral sides are formed by the backs and spines of A and B. The front and back of the rectangle each consist of a complete face, which is, of course, formed by one side of the face of A and the opposite side of B's face. Below this we have a thorax on each aspect, formed in the same manner. There is a single umbilicus, and below this A and B are quite separate and distinct. The base of the skull has a single hypophysial groove, otherwise it, together with the rest of the skeleton, is double. There is a heart on each side, formed by the opposite halves of A and B's hearts. The lungs in either thorax in the same way belong, the one to A, the other to B. There is a single fused œsophagus, which occupies the centre of the monster,

and a single stomach and intestinal canal as far as the opening of the omphalo-mesenteric duct; below this point the intestines of A and B are independent of each other.

Here we have supposed that the two fœtuses have been joined so that their sagittal axes form a straight line, and that the angle between them is, therefore. equal to 180 degrees. This condition, in which there are two complete faces, etc., is rare. It is far commoner for A and B's sagittal axes to be joined at an angle other than 180 degrees. In such cases there is a defect on the side corresponding to the smaller angle, which we can visualise by supposing that we have cut out a wedge of tissue in the middle line from the opposite sides of A and B before sticking them together. There will thus be a complete face on one side and on the other there will be a face which shows a varying degree of deficiency, and resembles that of a cyclops. In the same way the heart on the defective side will be more or less rudimentary.

(*d*) *Thoracopagus.*—In the commonest form of double monster, the two individuals are joined together from the manubrium sterni to the umbilicus. This is known as a Thoracopagus. As in the case of a Cephalothoracopagus, the sagittal planes of A and B may be fused at an angle of 180 degrees, or at some other angle. The amount of the anatomical changes to be found varies with the degree of fusion. It is always more or less superficial, and can be understood by supposing that A and B have been cut open by a median longitudinal incision, which extends from the manubrium to the umbilicus. The depth of our incision is variable, but does not reach much below the level of the bony thorax. If we now suppose that A and B have been stuck together, we shall find that there is a complete sternum and set of ribs on each side. There may be two hearts, which lie side by side, and each of which belongs entirely to one individual. If the hearts are fused, we find but one heart which is more or less double, and which occupies the median plane of the monster. The lungs are always unaffected. There are always two œsophagi and two stomachs. The small intestines may be fused as far as the opening of the omphalo-mesenteric duct, below which they are always independent of each other. The livers are usually fused on their ventral aspects.

Slight cases of this monstrosity, in whom the fusion extends only from the xiphoid cartilage to the umbilicus, are known as Xiphopagi.

Thoracopagous twins are viable, and occasionally reach a considerable age. The slighter forms, especially the Xiphopagi, have been separated with success.

I may mention that one occasionally meets with Craniopagi, in whom the crania are fused; Ischiopagi, in whom the fusion has occurred between the ischia, so that the heads look in opposite directions; Pygopagi, who are united back to back, and in whom there may be extensive fusion of the sacra; and Iliothoracopagi, in whom the fusion extends from the thorax to the posterior end of the body. These latter may resemble the anadidymus monsters very closely.

It will be seen from the foregoing that the two halves of the monster are always united by identical parts: face to face, thorax to thorax, ischium to ischium, etc. This seems to me to be a great argument in favour of the view that they are not produced by fusion of two originally distinct individuals, but by a process of fission of a single embryonic area, which had been almost, although not quite, complete. If the two halves had at one time been quite independent, it seems to me incredible that, when fusion took place, the same parts should invariably be able to hit each other off with such wonderful exactness. I have described these monsters as double, as they show a close relationship to monochorial twins, in some of whom the umbilical cord is single until quite close to its entry into the body. Also the generally accepted teaching is that they arise by fusion of two individuals. As this paper is meant only as a short exposition of the subject, I have thought it inadvisable to depart from the usually accepted view.

(*e*) *Asymmetrical or parasitic double monsters.*—We have seen that a healthy child may be accompanied by an acardiacus. It sometimes happens that the latter is not free, but is attached as a parasite to its fully developed brother. There are three situations in which it is principally found:—

i. Epignathus.

This form of parasite is attached to the palate or to its immediate neighbour, that is, the region of the upper pole or growing point of the body.

a. It may assume the form of an acardiacus, in every way similar to those that I have already described, whose umbilical cord is attached to the palate.

b. In other cases limbs or organs are attached to the palate.

c. More commonly an irregular tumour, which may be of great size, projects through the mouth. It consists of a fibrous stroma in which there are numerous cysts. Some of these cysts are lined by an epithelium which is epiblastic, and others by an hypoblastic epithelium. Structures resembling respiratory and intestinal mucous membrane are commonly found. The stroma contains cartilage, muscle, and other mesoblastic tissues. The three primary germinal layers of the embryo are, therefore, represented.

d. In the simplest form there is a tumour composed of tissues derived from one or more of the germinal layers.

The epignathi are, therefore, of great interest, since they show transitions between an acardiacus, a parasitic originally distinct individual, and an ordinary teratoma. I cannot here go into the matter fully, but will merely point out that teratomata vary greatly in composition. An ovarian dermoid, which is a typical example, may, and often does, contain deri-

vatives of all the germinal layers. This has been explained by some as an included twin formation. The better view to take is that it is derived from some cell which has become independent of the rest of the body at an early stage of development, at a time when the cells which then composed the embryo had not, as yet, become differentiated into epi-, meso-, and hypoblast. It, therefore, retained the ability to form representatives of all these layers. If a layer is not represented in it, this is due, either to its having been overgrown and destroyed by the tisues derived from one of the others, or to the parent cell having been split off from the rest of the body at a later stage, when it only retained the power of producing structures belonging to two layers. Again, whatever may be the cause of new growths, there can be no doubt that they actually grow from a cell or cells that have, in some way, lost the restraining influence of the surrounding tissues, and have assumed an independent active growth. We, therefore, see that the epignathi form several links in the chain between independent twins and ordinary tumours. This is also true of the forms I shall mention directly, but is not illustrated by them in such a striking manner.

ii. Sacro-coccygeal tumour.

These can be subdivided very much in the same way as the epignathi. They are situated in the sacral region, the inferior pole of the body. They occur most commonly as large cystic tumours, whose cysts are lined by epiblastic and hypoblastic epithelium. If the epignathus is a parasitic cephalothoracopagus, then the sacro-coccygeal tumour is a parasitic pyopagus.

iii. Epigastrius.

All that has been said of groups i. and ii. holds true of this group. They are attached between the ensiform cartilage and the umbilicus, and can be regarded as thoracopagi in whom one individual has become acardiac and parasitic on the other.

In conclusion, I wish to make a request with which, with greater wisdom, I would, perhaps, have headed this paper. If any of my readers should come across a monster in their practise, will they kindly send it to me in as fresh a state as possible, together with the placenta and membranes ?

Chapel Notices.

Nov. 22nd, at 8.15 p.m. in the Nurses' Home, Missionary Meeting. Speaker; Rev. E. F. E. Wigram, from India.

ADVENT.

There will be a short service in the Chapel on Tuesday, Nov. 30th, at 8.15 p.m. Preacher: Rev. R. P. Roseveare, and on Thursday, Dec. 9th, Preacher; Rev, R. M. Carrick. On Monday, Dec. 13th, in the Nnrses' Home, Miss Farrar will speak to the Missionary Society.

Letters from Guy's Men on Active Service.

From Lieut. F. J. Wheeler, R.A.M.C.
2nd Hampshire Regt., 88th Brig., 29th Div.,
Med. Ex. Force,
18th October, 1915.

Dear Sir,

I have not seen the G. H. GAZETTE since May last, but I believe you will welcome any notes from an old Guy's man. I came out on the Hospital Ship *Delta,* with 50 other doctors and 500 R.A.M.C orderlies. Within an hour of sailing from Southampton we had boat drill, and all officers and men were ordered to remain below decks until further orders owing to a submarine being "somewhere in the sea." After that we had an uneventful voyage. We stayed a few hours at Malta, and then went on to Lemnos, where most of us remained on the ship for five days.

Among the doctors I came across D. Allan, A. L. George; also Irvine, who came on board us at Lemnos from H.M.S. *Cornwallis* to spend an hour or so. A volunteer was required to take the place of an M.O. to a regiment at Cape Hellas (this M.O. had been killed) and I went. Landed at the Cape from a sweeper in the early hours of the morning. It is difficult to describe one's first impressions, but those I had in landing were very much those of a being entering a new world. I cannot explain without giving away information which the Censor would object to. After a 25 minutes' walk along a sandy mule-cart track I eventually arrived at my destination. The regiment were resting after the fierce battle of the 8th August. My next few days were spent in a recess in the cliffs. After that the regiment went up to the trenches, where I had my first experience of casualties.

We moved, after four days, to another series of trenches, situated at the head of some beautiful ravines. At this period the heat was intolerable in the day; now it is still sunny, but cooler, and the weather has broken. Another move was made, this time by sea to one of the new landings. I had the experience of marching across the plain on August 21st under shell fire. The scene in front was truly a wonderful one. On the great range of hills to which we were advancing our naval shells and the shells from the land batteries were bursting. Great clouds of yellow smoke, flame, and dust arose as the shells burst. The enemy's shells were hurtling through the air in return above us; occasionally some would fall short, and, intentionally, others intended for us would fall. It was a fine spectacle for a disinterested onlooker. The last 200 yards were bad, owing to shells falling and bullets whizzing past. We had orders to "dig in" at once. This was only just completed when we got an unexpected baptism of shrapnel. From this shell

fire I had my two medical orderlies, my servant, and half my stretcher bearers wounded. After that we moved by night to another position, and we have been in a series of trenches very near the enemy. As a result I have had some work to do.

Some wounds are horrible. One night a patrol of ours went out and all got wounded. The stretcher bearers got them in, and I set to work. It is by no means easy to dress wounds in a narrow trench where you hardly dare use an electric flash light. One of the cases was said to have been shot in the chest. On examining him I found the *whole chest wall missing*, and through the rib spaces, where muscles had vanished, I could see the lungs and the large vessels arising from the aorta. I put a big piece of gauze over his chest and sent him at once to the ambulance station. I made inquiries afterwards and found he lived to get on a hospital ship. The after history I do not know.

Some time I hope to write further on points of interest. The country here is wild and savage. Mountains, hills, nullahs, and ravines abound everywhere. The sides of these ravines are covered with great rocky boulders with a rough scrub between. Nearly all the shrubs out here are in keeping with the wildness of the country, being nearly all prickly and thorny. There is a small holly bush which produces acorns. (Whether there is such a plant as an holly-oak I do not know.) In the plains, fig, olive, and oak trees are plentiful, the latter producing huge acorns. The sunsets here are magnificent, and would be very difficult to portray accurately on canvas owing to the wonderful colouring. I will conclude now.

Faithfully yours,
F. J. WHEELER.

From H. Webb, Lieutenant, R.A.M.C.
Attached 1st Battalion Suffolk Regiment,
28th Division.
20th October, 1915.

"I have been up at the Front about a month, and arrived just in time to take a small part in the big push, which was a good introduction to modern warfare. I cannot say one enjoys the first few days of being shelled, but the life with a regiment is rather jolly, and once one is out of it, the actual strafering appears like a nasty nightmare.

"I met H. H. Davis in a dug-out and he helped me with some of my casualties. Godding is also in the Division, and I met him at a meeting of M.O.'s one day not long ago. Both seemed very fit. Elkington is attached to the regiment as machine-gun officer; otherwise I have seen no Guy's men since I left No. 25 General, where were Major Collins, the registrar, and Price-Jones. I am glad to be really in things. It makes one feel much easier in conscience when one is free from ties, but the Front is not the place for married medical men to strive for; of course, if it so happens they have to go, it is different.

"I do not suppose this is interesting enough for publication, but I thought a line about those I have met might interest you."

Lillehammer Turisthotel,
25th October, 1915.

Dear Sir,

Three numbers of the GAZETTE, each with an appeal to Guy's men on active service to communicate their address, have overcome my distaste for letter writing, though I think in justice to the others my name should appear under the title Passive Service.

I was appointed to the armed merchant cruiser *India* in April last and made several trips in her before she met her fate in the Vestfjord on August 8th in the form of a German torpedo. She was struck on the starboard side in the stern after a vain attempt to clear the line of white bubbles speeding towards her, and quivered violently when the explosion occurred. Everyone went to his action station, and then to his abandon ship station as the order was issued without any sign of panic.

The ship settled rapidly by the stern, listing more and more to port (the side away from the torpedo), and forging through the water at a pace which made it impossible to get the boats away. After clearing out the sick bay I went up to the boat deck in the hope that my boat might be launched, but it was obviously impossible, as the boat ahead was towing through the water practically gunwhale under, and immediately under our davits. The whaler astern of us was also afloat, and was cut adrift just in time to avoid being pulled under. Then a rush of water over my feet and it was sink or swim. I chose the latter, and after an eternity in a maelstrom, mixed up with rigging, wire ropes, etc., my floating waistcoat brought me to the top, and I was able to look around.

The last I saw of the ship was the bow rising nearly vertically up and then plunging under. I made my way through the wreckage to an upturned raft and was picked up cold but thankful two hours later by a British armed trawler.

I felt I had done my work, but was not allowed to rest, for bodies were being brought aboard, and some had a spark of life left. Attendance on them soon brought its reward in returning warmth. The water was, I believe, 53° F., and only very few men picked up after two hours immersion recovered. In nearly every case, in spite of the fact that the men were supported by lifebelts and the head well above water, the lungs were full of water, although there was only a gentle swell and and practically a smooth sea.

We were landed at Narvik the next morning, and there buried twelve of our dead. Then we were trans-

ferred to a Camp at Jörstadmœn, where we stayed for a month till parole was granted to the officers, when we moved to our comfortable quarters here. I am not allowed to treat our men, so have no medical duties at all, which is only a very little less than I had on the ship.

My hopes are mixed, for while I am looking forward to winter here with its attendant sports, I also want to get back to work again, which I suppose the Hague Convention Agreements make a possibility.

"They also serve who only stand and wait" again seems to be a suitable ending to this letter.—Yours sincerely,

FRANK W. LAWSON,
Temp. Surgeon, R.N.

October 28th, 1915.

Sir,

Your appeal for letters has been in the back of my mind for several days and any response is now actually materialising! Perhaps this is partly the result of a pricking conscience resultant upon your remark with regard to possible lack of time. Personally I can never remember having so much spare time—in fact there is too much. I am at present in charge of the health of an Entrenching Battalion. This really consists of a conglomeration of drafts waiting to reinforce various regiments that is used to provide workmen at the back of the front. Our men are at present becoming experts with the axe, saw and hatchet, and the products of their labour are used for sheds, supports, etc., for trenches, and firewood, etc. The sick parade occupies me for half-an-hour, and inspection of kitchens, latrines, etc., for, perhaps, another half-hour, after that it is a question of killing time.

I have been with various units out here since I left England last May, but have only seen one real engagement, or rather series of engagements, where we lost the trenches at Hooge on the occasion when the Germans were said to have used "liquid fire," and, afterwards, when we regained the lost ground. I was then in charge of a section of a Motor Ambulance Convoy, and got orders to take cars up to a collecting post just behind the trenches after dark. We started with five cars through the ruins of Ypres—an eerie spot in the dark, with guns of different sizes firing a variety of projectiles producing a hubbub which echoed and re-echoed across the horizon—for about three miles along a pavé road full of shell holes, till we eventually reached our collecting post behind a ruined farm along a narrow track. Here we found several hundred wounded on stretchers, while more kept coming in from an adjacent wood. These men had all been dressed, so that it was merely a question of loading them into the cars and despatching these as soon as possible. By the time we had the first cars loaded and sent off another batch of five had come up as previously arranged, and thus we kept up a continual stream during the night without getting the cars close together on the road.

About 2 a.m. we had cleared our collecting post and it was inadvisable to wait much longer as it began to get light about 2.30 a.m. and we should have been in full view of the Germans along our three miles of road, but at the request of the medical officer who was in charge of the evacuation of the wood I kept five cars for a further batch of casualties he hoped to get back to us. We took cover under our ruined wall after turning the cars facing home and proceeded to wait. Two wounded men arrived and were placed in the first car. About 2.15 a.m. the Germans sent up several coloured flares and then started attacking in good earnest again, and as we heard afterwards got within a few hundred yards of where we were. We remained under our cover listening to the various noises of battle and wondering exactly what was happening. Personally the bullets clipping the leaves off the trees above our heads impressed me, I think, most.

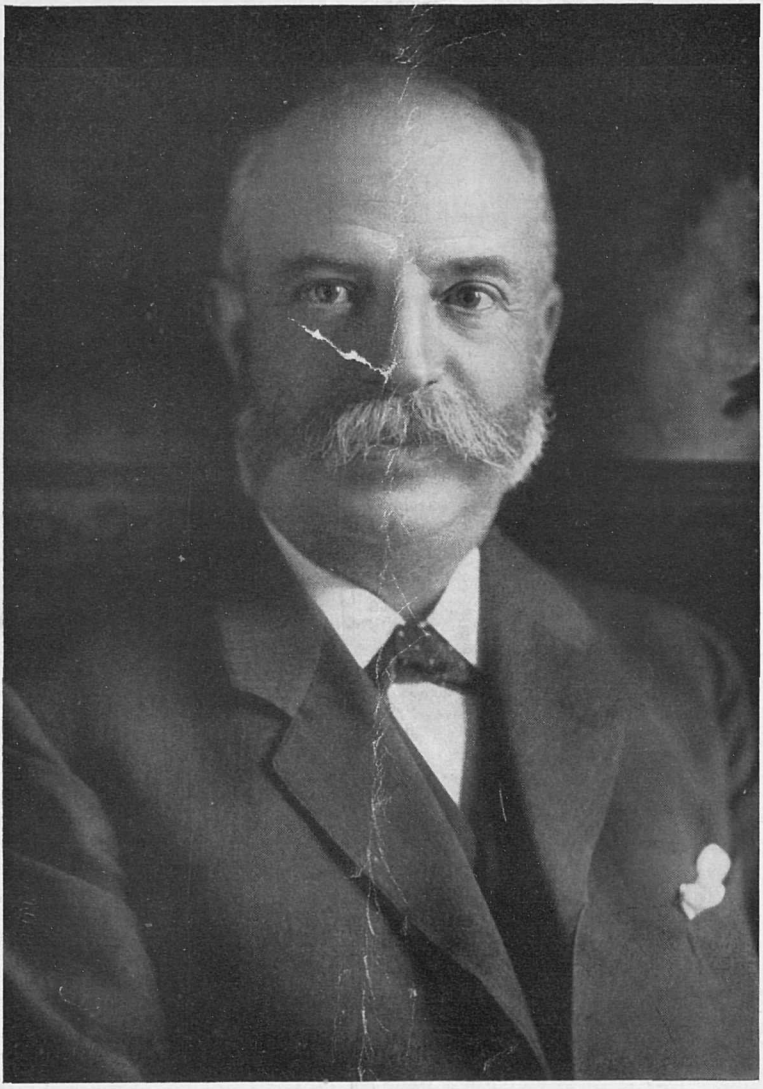
Eventually it became evident that no more wounded could get back along the foot path from the wood, and it was a question of trying to get the cars with their personnel out of danger. Each car went off in turn—we found that the last car had a punctured tyre, but I decided to disregard this, and after some difficulty in getting the engine started we got away, driving as fast as we dared, swaying from side to side of the road, and bumping in and out of pot holes and shell holes.

About half-way back we found a large tree freshly blown off by a shell and lying across the road, luckily we had just room to get round, and so we eventually reached Ypres where we drew up to examine the tyre. I found that there was no tyre or rim of the wheel left, and that we had been running on the spokes which were worn down to about half their length. We backed under better cover and changed the wheel, and completed our return journey safely, and thus ended an exciting night. We carried no burnt patients at all, and I could never hear of any number who were burnt, so that the reports about the liquid fire appear to have been exaggerated. We visited the same position on several future occasions but never had such an exciting time again.

So much for a somewhat inadequate description of quite an exciting adventure.

In conclusion, I would like to remark that, while making due allowance for increased work which would result from any considerable action, and after thirteen month's experience with various units, it is my considered opinion that their is very considerable room for economy in the use of medical officers, and I do not think it at all fair to press men to leave their families and valuable practices until fuller use is made of the men who have already joined.

W. T. CHANING PEARCE,
Temp. Capt. R.A.M.C.



Chas. D. Wells

Clerk to the Dean. Secretary to the Treasurer. Clerk to the Governors.

Guy's Hospital, 1880—1915.

Charles Henry Wells.

By the retirement of Mr. Wells there is lost to this Foundation one of the strongest and most useful of men who ever served the allied cause of the Hospital and Medical and Dental Schools. Combined with character and natural gifts, his strength lay in an unobtrusive devotion to work and duty, seldom equalled, perhaps never surpassed in our small sphere, and no man on reaching his 60th birthday, after 35 years of toil within these precints, has been entitled to say with better grace, I have ploughed my last furrow; let me rest and see the fulness of the harvests yet to be garnered by other hands.

Mr. Wells came to Guy's from a London Banking firm in 1880 as Clerk to the Dean, then Dr. Frederick Taylor, and his early experience of finance stood for much in the future. Yet Mr. Wells, sound accountant as he be, would say, "I am not an orthodox disciple of the modern professor in figures, but I can prepare a Balance Sheet," and he could, and that a correct and honest one. Why this man of figures left his financial stool in the City to deal with irreverent students is only explicable by his instinct for work in a wider field of activity. It has been said that he mistrusted the stability of Banking and preferred a safe and quiet occupation, and so by the irony of events he became in later days a frequent visitor to the parlour of the Bank of England in the interests of the stability of a great Charity. But 1880 is a long time ago; the Medical School Office was a sedate institution content with things; so having taken students' fees, given them sound information and, on occasion, solemn advice as to their present conduct and ultimate future, the Clerk asked the Dean for more—more work—and to satisfy his desire many a lowly clerical task was to his pleasure discovered. However the desire of Mr. Wells for more work and of a higher grade was soon to be met.

Dr. Perry, as he then was, succeeded Dr. Taylor as Dean in 1887, and since Sir Cooper Perry took office at Guy's with an intention, it followed that there then began a big effort to improve the state of the Medical School, to advance the scientific instruction in Dental Surgery and its application to the needs of the people, to build and establish a Residential College and Club for the Residents and other Students of the Hospital to the comfort and joy of generations of good men. In all these proceedings Mr. Wells had his big part, and for the time being his desire for work in higher planes was satisfied. With these things completed and Dr. Perry having succeeded to the office of Superintendent, Dr. Lauriston Shaw became Dean, and some new ideas were incubated, Mr. Wells again being a party—the Clubs' Union, the Sports' Club and Ground at Honor Oak Park, the New School Buildings came into being. It is probable that Dr. Shaw will confirm the impression of the present writer that Mr. Wells conceived the idea of the simple domestic financial scheme that secured the freehold of Honor Oak Ground for Guy's men, and it may be hazarded that his zeal in all that went to the well-being of the Clubs' Union in its beginning was the secret of its success. There is in any case good evidence that Mr. Wells went to Tattersall's and bought the first horse used by Harris to keep the ground in order. He selected the particular animal because of its kind eye, but it is characteristic that he secured a bargain at a pound a leg. But in these times, perhaps, the most outstanding incident was the revival of GUY'S HOSPITAL GAZETTE, which first founded in the sixties, was suppressed by the authorities some years later because of the contumacious conduct of the editors.

Under stern conditions, publication was again permitted, and Wells was one of the prime promoters; he was appointed Manager, and has remained so to this day. That is why GUY'S HOSPITAL GAZETTE exists as the premier hospital journal, and for the simple reason that he insisted on a regular fortnightly publication, every second Saturday, and likewise on the report of a Clinical Lecture. It was a hard struggle but he won, and amongst fellow workers made many friends, of whom one may recall the late Mr. J. H. Targett, for long time Chairman of the New Committee. Thus occupied with these and other activities, in addition to work of routine, Mr. Wells spent his first fifteen years at Guy's Hospital.

Then came his great call. The Governors, in view of the critical loss in revenue from the original Endowment, had to face the necessity for raising at least £20,000 per annum from voluntary sources, and, as it transpired, much more money to meet further issues essential to the preservation of Guy's Hospital in its foremost place before the World. They required someone to undertake the task involved, and requested from the Medical School the help of Mr. Wells. This was accorded. Mr. Wells accepted the duty, and from 1895 has been the creative force in the financial regeneration of the Hospital. He founded the Sustentation Fund, the Re-endowment Fund, and other funds, which in combination must by this time nearly have achieved a result equal to a million pounds. And he did it by aiming high. The first morning he sat in his new chair there was a letter from an old lady enclosing a cheque for £100. With this in hand Mr. Wells approached Mr. Gladstone, then Senior Governor of the Hospital, and it may be said that the Grand Old Man's letter published in the Press on the 18th October, 1895, was the finest and most successful effort of his later life. Things began to move, and King Edward VII threw in his powerful influence. But it is the simple truth that Mr. Wells saved Guy's Hospital when he appealed for £500,000 to make good the loss on the old lands in Essex, Lincolnshire, and Hereford, and to promote that end used to put on his hat in the morning time, and armed with no more than a simple card of introduction, set forth to see some rich man, ask him for £25,000 and return crestfallen with only £5,000 for re-endowment.

When Thomas Carlyle defined genius as "an infinite capacity for taking pains," he must have had on his horizon Charles Henry Wells, who has won the respect of all men, the grateful thanks of many, and remains ever the faithful servant of Thomas Guy.

AT A GENERAL COURT OF GOVERNORS,
Held on Friday, November 5th, 1915.

The President read a letter from Mr. C. H. Wells, resigning his appointment as Clerk to the Hospital and Secretary to the Treasurer, on 13th November, 1915, when he will attain his 60th birthday, and moved that:—

"Whereas the retirement of Mr. Wells from the service of the Hospital presents a suitable opportunity for expressing the high appreciation in which he is held as a faithful and courteous Officer, therefore be it:—

RESOLVED: "That the best thanks of the Governors are due to Mr. C. H. Wells for the able and efficient manner in which he has uniformly performed his duties, as Secretary to the Treasurer, and latterly as Clerk to the Hospital, together covering a period of 20 years; and further, that he carries with him, on leaving the positions which he has so satisfactorily filled, the esteem and good wishes of all who had occasion to transact official business with him. While they regard his retirement to private life as a loss to themselves and to the Hospital he has served, they sincerely hope that he will now be able to enjoy a period of well-earned rest, and experience much happiness in the future."

The above Resolution was accompanied by the Presentation of a handsome Silver Tray, engraved with the arms of the Hospital and this inscription:—

Presented to
CHARLES HENRY WELLS, ESQUIRE,
Secretary to the Treasurer and Clerk to Guy's Hospital,
on the occasion of his retirement,
November 13th, 1915.

In recognition by the Governors and Medical Staff of the valuable services, extending over a period of 35 years, which he has rendered to the Hospital and Medical School; and in appreciation of his strenuous and successful efforts for the Re-Endowment of the Charity.

The Officers and Servants of the Hospital, Medical School, and Nursing Staff followed the lead with an Illuminated Address in album form. The text appears below, and bears one hundred and eighteen signatures.

To CHARLES HENRY WELLS, ESQUIRE.

On the occasion of your retirement from the service of Guy's Hospital, we, your fellow-workers, Officers and Servants of the Hospital and Medical School, and Members of the Nursing Staff and Trained Nurses' Institution, desire to convey to you an expression of our esteem and regard. For many years we have had experience of your kindness and courtesy, and to not a few of us your ready help and sound advice have been invaluable. We are glad to know that your long association with Guy's has been a source of happiness to yourself and of lasting benefit to the Charity, and we trust that in your retirement you will regain such a measure of health as will enable you to enjoy your well-earned leisure, keeping always a kindly memory of the Hospital and its Medical School, with the welfare of which your life's work has been bound up.

Serbia.

V.—SERBIAN IDEALS.

Tout bouge, et l'on dirait les horizons en marche.
E. VERHAEREN.

The sudden and tragic prominence of Serbian affairs which day by day grows more acute, and the consequent widespread interest taken by the general public in the aims and aspirations of our gallant little ally is my excuse for this brief and very imperfect survey, which has given me more pleasure in the writing than I can ever hope the reader will derive therefrom.

The history of the Balkan peninsula is one of kaleidoscopic changes, vast, shifting empires, feuds, rebellions, race hatreds which may well baffle the student in search of coherence or continuity. Their early records have almost all been lost in the course of the ceaseless wars in which for two thousand years they have been engaged, it is only by rare fragments, scanty and ambiguous passages in Greek or Roman historians that one can formulate a guess at their origin. It seems, however, to be generally agreed that the original home of the Slavonic peoples, or rather the home which for all practical purposes may be considered original, lay to the north of the Carpathians, between the rivers Vistula and Dnieper; probably it included the whole upper basins of the two rivers. Those Slavonic people who are now called the Southern Slavs must gradually have migrated first over the Carpathians into the plains of Pannonia, the modern Hungary, and the valley of the Danube, and later across the Danube into the Balkan peninsula. It is well known that the Slav occupation of the Balkan peninsula is comparatively recent—towards the end of the sixth century—but when they crossed the Carpathians, and what happened between that time and their crossing of the Danube it is only possible to conjecture.

It was during the first half of the seventh century that the Slavs, together with the Avars, a tribe from Asia, began to penetrate from Pannonia across the Danube into the Balkan peninsula. At that time Byzantium was fully occupied with wars against Persia and could spare no men to withstand the inroads from the north. The emperor was compelled to pay the invaders tribute. In the second half of the century the power of the Avars declined and the Slavs continued the invasion of the peninsula on their own account. Soon they had conquered from the Danube to the Ægean, the emperor was helpless, and agreed to their occupation of the territory if they would stop any further inroads from the north, and recognise his suzerainty. The original inhabitants whom they displaced seem to have been of the same stock as the modern Albanians, neither Greek nor Slav, but speaking a tongue sprung from the same root language as Latin. These invaders, however, were not a homogenous people, but rather a loosely knit series of tribes, each under their own leader and united merely for purposes of conquest. Soon they began to group themselves into two main divisions—an Eastern and a Western. The Eastern division came subsequently to be known as Bulgarians (in Albania to this day they are called Shkyar, a Scythian), and though strictly they are a Slav people, their extensive intermarriage with Turks, Tartars, Gipsies, Goths, Huns, etc., has destroyed the purity of their racial characteristics. Moreover, its closer proximity to Constantinople made it easier for the Turks to obliterate the national spirit by planting colonies in their midst. The Western division, on the other hand, remained in a much greater degree unchanged, the language retained its origin, inflexions, and case endings, which in the case of Bulgarian were lost, its remoteness from Byzantium made it difficult for any formal conquest or colonization to be attempted, and it was not until the close of the fourteenth century, as we shall see, that their conquest by the powerful Turkish empire was achieved.

In the ninth century the Greek missionaries Cyrillos and Methodius came to the Balkans, reduced the language to writing and founded the national church; Christianity had previously made some headway in the peninsula among those Slavs who were in contact with the Greeks, but up till now the Bulgars were a Pagan people. In 866, however, Boris, their king, was baptised and hastened the conversion of his subjects by beheading the unwilling. His son, Simeon, carried on to conquest the empire which his father had built up well and truly. Everywhere he was victorious. The Serbs were forced to submit, the wild Albanian tribes driven back to their own coastline. Even Byzantium paid him tribute. His was the first of the one-man empires so common in the history of the Balkans. His capital, we are told, was of extraordinary magnificance. From Ochrida alone, in 1017, he captured 10,000 pounds weight of gold. For a while the scarcely emerged Serbian race vanished. Warred on by Greek, Bulgar, and Hungarian, one wonders they survived at all. Then, in 1150, the first of the great Nemanya line of princes appears, and we have, if not continuity, a definite royal tradition. Crowned King of Serbia in 1185, he reigned till 1196, during which by a steady policy of expansion and reform, he succeeded in adding enormously to the territory and cohesion of the Serb people. His son succeeded him, and for long the Nemanya line ruled over Serbia, gradually replacing the decaying Byzantine empire, till by 1330 they were the undisputed rulers of the peninsula.

But a new and unsuspected foe was approaching. The Turk, though held in check by the victories of the crusades, was steadily gaining power, and it was

at the highest point of the Serbian empire that the danger grew most real. Under Stefan Dushan (1337-1356) the Serb territories were extended to Belgrade, in Bosnia, along the whole of the Adriatic coast, as far as Roumelia, and even Bulgaria was counted as part of his kingdom. His wealth enabled him to profit by the civilisation of Italy, and we find in his service bands of *condottieri*, and architects from the republics of Venice and Ragusa erecting at his command churches and palaces. At Ipek, near the present Montenegrin frontier, stands a beautiful white marble edifice which he had erected by an architect of Cattaro in memory of his father—whom he is reputed to have strangled. His reign may be said to mark the transition from the period of entire lawlessness to one of incipient order and justice. He framed a code of laws, written in pure and dignified Serbian, providing for the rights of individual ownership, and punishing those who molested private citizens. It was a common saying last century amongst the Serbs under Turkish rule, that one was safer under Stefan Dushan than the Pashas. His name, indeed, has passed into the national ballads as an ideal as lofty as that of King Arthur or Roland de Roncesvalles. After years of unceasing conquest he set himself in 1355 to capture Constantinople, and at the head of an army of 80,000 veterans marched triumphantly through Thrace and took Adrianople by storm. Sure of his goal he advanced on the capital city of the Ottoman Turks, and almost within sight of its gates was stricken by a deadly sickness, the victim, as was said, of the arts of the poisoner. Thus, after twenty years of unparalleled conquests, the greatest Tsar of the Serbs died before he had placed a barrier between his people and the Turks, who were so soon to prove a deadly menace.

The son who succeeded him, Urosh II., was weak and vacillating. The huge army retired in disorder from Constantinople, and in the short space of two years there were revolts in Thessaly, Acarnania, and Epirus; Bulgaria and Albania threw off the Serbian yoke; Belgrade was captured by the King of Hungary. Vukashin, a chieftain of Epirus, seized the southern part of the land and bodly proclaimed himself king at Uskub. The Turks were everywhere advancing. and Serb and Greek allied forces were powerless to oppose the recapture of Adrianople. In 1371, Vukashin, who had by this time murdered young Urosh and placed himself at the head of the Serbs, engaged the Sultan Murat I. on the banks of the river Maritza with a force of 60,000 men. They were completely defeated, and he himself murdered by a Serbian nobleman, who thus avenged the death of King Urosh. The advance of the Turks was now steady. In 1385 they took Macedonia, in the following year Nish fell into their hands. The position of the Slav peoples was desperate ; nothing short of a desperate and united effort could save Balkan Christendom. Stephen Tvrtko, a descendant of the Nemanya line, King of Bosnia, contracted an alliance with Lazar Grebelyanovic, who had been elected King of Serbia, and together some successes were won against the Turks. This stung Murat into renewed activity, and in 1389, with an enormous Moslem host, he advanced to meet the combined forces of Bosnians, Albanians, and Serbs under the leadership of Lazar. The forces met on the plains of Kossovo, in the heart of old Serbia, and the battle which ensued took that name. The day was fateful in the annals of civilisation and the Slav peoples. There was treachery on both sides. The Sultan was stabbed in his tent by Milosh Obilich, a Bosniak in his service; Lazar was slain by Vuk Brankovic, his son-in-law, who coveted the crown and who deserted with 12,000 men. The Turks, though they lost heavily, were victorious, and till 1912, the day of the battle was celebrated with mourning services throughout Serbian lands. For, as a result of the battle, the cause of Serbian nationality was put back 500 years, and what had but forty years before been a victorious kingdom became an obscure province of the Ottoman empire. The long night of Turkish misrule had fallen.

I have dealt at some little length with the early history of Serbia in order that it may be clearly recognised that the gallant fight for freedom commenced by them in the last century and which in the present war has had so tragic a *dénouement* has every justification on national and racial grounds. Until the war of liberation of 1804, if war it can be called, the history of the country is one of increasing oppression and degradation. Under the rule of the Janissaries, vigorous attempts were made to stamp out entirely the Serbian nationality—the story is one of pitiless massacres, extortion, rapine. But a limit is reached in the power of a people, however poor and beaten, to submit, and in the fastnesses of Montenegro the flag of Slav liberty had always been kept flying. In 1804 a peasant, Kara George, who had seen service in the Austrian army, succeeded in collecting a powerful band of peasants, and swooped down upon Belgrade, routed the amazed Janissaries, and seized the city. Flushed with their success, the Serbs asked the Porte to withdraw all garrisons from Serbia; for an instant the Porte wavered. But the moment was unfavourable. Europe was in the throes of the Napoleonic wars. Russia, though willing to help, was fully occupied (since 1711 there had been a Russo-Montenegrin alliance), Austria was opposed to the formation of a powerful southern Slav federation. The moment passed. The Turks despatched a strong force from Nish, which Kara George easily defeated. Determined to vindicate their position, they sent against him two strong armies which, to the general astonishment of Europe, were again beaten. In 1807 Russia declared war on the Turks and called upon the Serbs to assist her. Kara George captured several provinces, but in 1812 the Treaty of Bucharest, which Russia concluded on being again threatened by Na-

poleon, led to the recapture by the Turks of almost all that had been gained. Kara George fled to the mountains, and the Serbs, left leaderless, were subjected to the tyranny of the vindictive Suliman Pasha. But in 1815 appeared another of those leaders, whose exploits have done so much in the making of Serbian history. Milosh Obrenovic, one of Kara George's old generals, rallied the people once more, and defeated the Turks in several small engagements. The overthrow of Napoleon left Russia free to aid them, and this consideration induced the Sultan to grant them a weak autonomous administration under the rule of Milosh. After much diplomatic shuffling, the Porte at the instance of Russia agreed in 1826 to consider the privileges demanded by the Serbian peoples, and in 1830, after the war between Russia and Turkey, Milosh was acknowledged hereditary Prince of Serbia. From this point the independence of Serbia was fully established, and it would be wearisome to enumerate all the steps by which her position among the European nations became fully recognised.

The root of the present conflict may be traced to the Congress of Berlin in June, 1878, which ratified the provisions of the Treaty of San Stefano, concluding the Russo-Turkish war of 1877—78. In this struggle the Serbian armies had rendered valuable services, capturing Pirot, Vranya, and Nish, and of these she was allowed to retain the two former in compensation for guarding the railway and commercial rights of Austria. The kingdom of Montenegro, however, was separated from Serbia by the Sanjak of Novibazar, and the administration of Bosnia and Herzegovina handed over to Austria. The action taken by the Congress of Berlin was a grievous dissatisfaction to the Serbian people. The project of a great Serbian kingdom was an ideal treasured in the hearts of many, and the shameful oppression of Serbs in the two provinces under Austrian administration was bitterly resented. Their fidelity to the Orthodox Church was made the subject of heavy exactions, and attempts were made to stamp out the language. (In Croatia 95 per cent. of the population are Croat or Serb, in Dalmatia 92 per cent.) The subsequent dangers to Serbia have been not from the Turks, whose power has been steadily on the wane, but from the Austrian fear of a Serbo-Croatian alliance. The aspirations of the Serbian people have turned always to the sea, and if a union could be consummated between them and their blood brothers, the Slovenes of Bosnia, this ideal would have been realised. It is with this in view that Austria has constantly sought to threaten their liberties and hold over them the mailed fist, military and economic, in order to keep their government sufficiently humble. Thus, for example, if there had been any brisk signs of a Pan-Slav coalition, or some such propaganda was suspected, Austria would declare that swine fever had broken out in Serbia and prohibit the export into Austria of Serbian pork. As this formed one of the principal sources of wealth of the country, the point, whatever it might be, was perforce conceded. The notorious Agram sedition trial of 1909 was a case of this sort. Fifty-three Serbs were arrested on the charge of being concerned in a Pan-Slav plot against Austria. An excuse was desired for the annexation of Bosnia and Herzegovina. The trial was conducted among scenes of the greatest possible scandal, the judges were publicly drunk on the bench; the greater part of the evidence was proved to be impudent forgeries. Nevertheless, the prisoners were found guilty and sentenced, though the penalties were afterwards remitted at the instance of Great Britain. Such another case was that of the Austrian Consul, Prohaska, at Prisren, who suddenly disappeared, and whom it was alleged had been murdered by the Serbs. Subsequently he reappeared, and admitted that the whole affair had been done at the instigation of Count Fourgatch at the Austrian Foreign Office. It is interesting to note in this connection so widespread was the feeling against Austria that one of the murderers of the Archduke Ferdinand was the son of a Bosnian police spy.

There can be no doubt that the press agitation against Serbia in the Vienna papers after the Sarajevo murder was part of a carefully prepared scheme of aggression on the part of Austria, and intended to provide a pretext for the "punitive expedition" with which she hoped to crush for ever the hopes of a Jugo-Slav federation. That by her ultimatum she would precipitate the present European conflict she cannot for a moment have suspected. But in the consideration of the terms of a future peace some settlement of the Balkan problem for all time must be attempted. Due regard must be had to speech and religion, the ancient limits of the Serbian Empire, the wishes of the people themselves. There is no doubt that the formation of a strong Pan-Slav kingdom, comprising Serbia, Montenegro, Bosnia, Herzegovina, and much of the southern Hungarian plain north of the Danube, would, if properly guaranteed by the great powers, satisfy the aspirations of a population of some fifteen million souls, ten million of whom have always lived beneath a flag not their own, and subjected to all the disabilities of such alien rule.

One afternoon at Nish, it was the day of the feast of St. Sava, I passed through the little churchyard of the cathedral, where two old men guarded a flock of goats with tinkling bells, and, pushing by the heavy curtains, entered. Coming from the angry tumult of the winter sky, the interior was dim, a lustrous dusk, illuminated by the soft radiance of a thousand star-points. As I listened, the notes of a canticle, floating softly from the choir, was caught by the sexless sweetness of a chorus of boys high up in the gallery. The melody, now sudden and dramatic, now haunting in the universality of its appeal, was tossed from one to the other, filling the brooding mysteries with plan-

gent harmony. The service could only have been conceived by a poet, it needed a mystic for its full comprehension. It achieved that union of strangeness with beauty of which Pater speaks as constituting the romantic. The august dignity of the language, old Church Slavonic, as far removed from that of the people as the tongue of Chaucer is from our own, the gorgeous vestments, the incense, the rhythmic movements of the priests, the blaze of candles before the dark-faced *eikons*, made it an experience odd, strangely thrilling. Perhaps here, I thought, is to be found the secret of a race which for a thousand years has braved the foe within and without, the pestilence and the sword. G. H. F. G.

[In the previous article of this series the mild endemic form of typhus prevalent in the United States known as Brill's disease was by a misprint designated Bull's disease.]

Nursing News.

From Miss Hillard. No. Ambulance Train,
British Expeditionary Force,
October

"Am now in charge of above train and on the whole like the life very much. It is a great change from the base hospitals, though of course the work is much better in hospital, there seems so little we can do for the men on the train. When a rush is on and we get them straight from the field ambulances we have all the dressings to do.

"The C.O. on this train gets a most delightful supply of little pillows and I find them most useful in making the fractures more comfortable.

"This is not one of those delightful looking kahki trains, but one advantage is the men are saved much moving as they remain on the stretchers from one hospital to another. The great disadvantage is that the carriages are not connected and we have to jump down (and a big jump too without a platform) and run from coach to coach when the train stops..

"I am better off as the officers part is connected. I often wonder if any of the officers I bring down will arrive in Stephen.

"One of the Corporals on the train is Morris, from the Guy's Works Department. We shall be very sorry when he leaves in November, as he has been a great help. He is a Reservist and has finished his time.

"I have only been back to Etaples twice since coming on the train, and each time we have begun loading patients to take to the boat for England at 6.15 a.m., so that I don't think I could have been a very welcome visitor at that hour. I was very sorry to leave all Guy's friends there, but nearly every one likes the variety of train life for a time. When we are up country waiting for orders to load, we can generally hear the guns all the time; of course I have no experiences like the sisters who went out at the beginning, everything now is so well arranged. My first class carriage for sleeping in is most comfortable, and we have another carriage for dining and sitting in."

From Miss Lorna Wood;—

British Red Cross Hospital, No. 7,
Montazah, Alexandria,
15th October, 1915.

"We have over 600 beds now (always full) and are building fast; there is so much sickness, very few wounded coming in. The men are supposed to come to us convalescent, but they are all pretty ill and exhausted and are sent to us as soon as they can be moved from the Alexandria Hospitals—very few, comparatively, boat or bathe. It is getting delightfully cool here now and I enjoy my morning drive from block to block in a dog cart with a splendid little grey arab horse, it is going round the wards de luxe, isn't it, specially as all the roads leading to the different buildings are beautiful with all kinds of flowering shrubs and trees.

"I had two copies of the GAZETTE this mail and enjoyed reading about the concert in the nurses' home, it must have been a great success.

"I met Captain Champion in Alexandria and he told me of Mr. Vennables illness so I went in to see him, but he had just left for England.

"This is no country for Englishmen to get well in—the milk and eggs are poor, the meat worse! and there are no vegetables, while the bread is appalling! feeding our 600 is a great business but the caterer really does it very well and the men are extraordinarily well fed—for Egypt; the Australians grumbled a bit at first because they couldn't have beef steaks for every meal, but they are absolutely no trouble now and are magnificent looking men physically and very interesting—I always feel it is rather hard on our men, that they should get 6s. a day and Tommy only 1s., but our men never grumble and seem to think its not *their* business if the Australian Government likes to be generous, I suppose the army won't or ought not to exist some day when there is an end to war—but at present it does make tremendously fine men, all these men and boys here seem to have all the qualities and virtues worth having and it makes one's heart ache all the time if one stops to think of what they are getting well for.

"I was very glad ty hear that Guy's had not suffered in the air raid, there were the wildest rumours going round here—we rely on letters for all our news, as the Egyptian newspapers appear to be very heavily censored.'

From ——

No. 13, General Hospital,
Expeditionary Force,
October 25th.

"I expect you will be wondering why you have not heard from some of us for so long; it hardly seems as if we had been here nearly three months. As our letters are censored we can't say very much, so I suppose that is why we do not write many.

"Our Hospital is the Casino, and I believe it is supposed to be one of the finest out here. The ward I was in on day-duty was originally the Restaurant and

made a beautiful ward. It is known as the 'Glass House,' as it is nearly all windows, and we get plenty of sun and fresh air. We had a lovely view of the sea and a nice balcony, also a cold water tap which is an unknown luxury in most of the other wards! Usually the water has to be brought up in cans and boiled on oil-stoves Our 'kitchen' consists of a wooden table screened off at one end of the ward.

"I am on night duty now in what was once the Theatre. Here we have no windows at all, only five glass doors all of which open on corridors, so we get no real fresh air, but fortunately the ceiling is very high, and there is a gallery above, so the ward does not seem to get stuffy. The walls really serve as windows as they are mostly glass, but of course they do not open. There are eighty beds here, and Miss Johnson and I are in charge on night with two orderlies. We each have our own side like the Medical Wards at Guy's. Miss West is in the next ward—once the Ball-room, and we can see her through our glass walls. Misses Raven, Lithgow, and Adams are on day-duty, but I believe they will soon join us on night. We stay on about two months at a time. It seems rather a long night, as we are called at 6.30 p.m. and are on duty from 8 p.m. to 8 a.m., we have our meals in the ward. The day-staff come on at 7.30 a.m. and are off at 8 p.m., and they usually get three hours off unless we are busy. We had a rush about two weeks ago after that last advance, but things have been quiet lately. We never keep our patients long as they are sent to England as soon as possible.

"We have seen several Guy's people at different times. No. 26 is about eighteen miles away, but I'm afraid we shan't get an opportunity to visit it, though we see friends from there occasionally as they pass through Boulogne on their way home. I saw Miss Cosley several times when she was at No. 14. Mr. Sherriss was here, but was moved to a Clearing Station a few weeks ago. Mr. Seabrooke is a few miles away at No. 14.

"Misses Raven, Adams and Lithgow, have moved to our Hotel, so Miss Johnson is left alone at the other one. She has the advantage of being almost opposite the Hospital, but otherwise, our quarters are more comfortable. We are nearly a mile away, but we usually have a motor ambulance, so the distance does not matter. There are two other large Hospitals at Boulogne, and several more under canvass a few miles away. They are very busy finishing huts for the winter, they must be a good deal warmer than the tents.

"We consider ourselves lucky to be under a roof for the present, as the winters are very wet here. I can't understand why they are always short of water when they have so much rain. The taps are nearly always turned off for a certain time each day, and if there are hot and cold taps in a bath room they are never both working. Usually one tap is considered enough, and the water is either stone cold or boiling, However, it is something to have a bath at all. We have a nice Club where we can get tea and read the English papers."

Camp and Field Work.

Dear Sir,

Possibly a few notes from practical experience on the making of latrines for the troops in the field may be of interest to other Guy's men who have this sort of work to carry out. The system is probably known to all and is of course no invention of mine as I had no experience in these matters before the war, but I have learned so many useful tips that I should like to hand them on. The main difficulty at the Front is that we have not an unlimited space to cut the usual trench latrine in, and the French Government have expressed the desire for economy in this matter. So many men are collected in comparatively small areas that the ground soon becomes used up. To meet this difficulty the cinder pit is being used. The Divisional Sanitary Authorities first explained the system to me, and it is to them I am indebted for first thinking of it. The principle is this:—Choose a spot preferably with a very slight slope, then have a pit dug which should be 5 feet deep by at least 4½ feet square. I find 4½ feet is the minimum that enables a man to work comfortably inside for digging. A trench is then dug leading into the pit, starting, where possible, on the spot that is slightly higher than the pit. This trench should be about 10 feet long. The end which is distant from the pit is 1 foot deep and it gently slopes to 18 inches and the width is also 18 inches. The whole is now filled with cinders to the brim, both pit and trench, so that all is level with the ground. On the cinder trench place four empty oil tins. We get plenty of these out here, especially if attached to a motor lorry ammunition column. These tins should be four gallon ones. The top is cut off and the bottom perforated, a layer of straw is put at the bottom which is soaked in 5 per cent. cresol.

The usual wooden seats are made, and in all cases I make a point of having ample and comfortable head cover and when possible cover the whole with a tarpaulin; when this cannot be obtained we use the wood from cartridge cases or old galvanised iron, and if a house near is very badly shelled and in process of dissolution, useful pieces of wood have been known to miraculously appear at my bidding next morning. The excreta is passed into the tins and all fluid percolates into the trench and thence slowly into and right through the pit and is perfectly filtered. I find that Chloride of Lime sprinkled on and around the trench and pit is an advantage though not a necessity. It is also a good plan to have the cinders raked over daily to ærate them. The contents of the tins are daily burnt, and I find 8 a.m. is the best time.

This means a good brick incinerator. It is here my greatest difficulties have been. My unit is a Brigade of heavy guns, and the separate gun positions and ammunition long parks make seven or eight distinct camps, and in each of these I have the system working. The best sort of incinerator is on the old bee-hive principle and

requires about 300 bricks. It should have ample openings below for raking out, and on the curve of the dome above near the chimney, a large opening or shoot which can be made also from a large petrol tin. The bricks, if new, cost me 15 fr. per 1,000 or old 7·50 fr., but usually these can be got for nothing if the houses near have been shelled to ruins. Amongst the gunners, a man who understands the mysteries of laying bricks can usually be found, and he miraculously makes them curve into a dome without all falling inside. On these occasions I stand by and admire. Gunner Brownless in particular entered into the scheme most enthusiastically, and has made his arrangements work splendidly.

The fire is lighted half an hour before the tins are emptied, and should, of course, be a fierce one, and in about an hour nothing remains but a very fine ash.

Twice a week, at least, the tins should be burnt out inside, and once a day the cinders raked lightly over.

The latrine I have described is for 50 men, and several have been in constant use for two months, and as yet show no sign of being used up.

Hoping these few notes may be of interest to you,

Yours faithfully,

C. F. HARDY,
Temp. Capt. R.A.M.C.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

From O.C., 2/2nd Home Counties Field Ambulance, R.A.M.C. (T.), to The Secretary, Guy's Hospital, London, S.E.

SIR,—I, as an old Guy's man, am writing to ask your help in obtaining four Medical Officers for this Unit, and also four to act as Regimental Medical Officers to the four Middlesex Battalions in this 67th Brigade—making a total of eight—who are really urgently needed in order to cope with the work.

At present I have to detach four of my officers to act as R.M.O., leaving only myself to look after the Hospital, besides a lot of outside work which devolves on me as Senior Medical Officer of the Brigade.

As regards the respective advantages of joining the Territorial Force, or becoming a temporary Commissioned Officer, I would strongly recommend the T.F. in preference for the following reasons:—

1. Promotion to Captain, with that rank's pay and allowances after six months service. (*Note.*—A T.C. Officer, although promoted in the same way, receives no extra pay or allowances).

2. Precedence. A T.F. Officer, even if junior in rank to a T.C. Officer, is always the senior as regards precedence.

3. Gratuities. A War Office letter has just come to hand, and "an Army Order on the subject is about to be issued," stating that at the end of one year's service a gratuity of 124 days pay will be allowed, and 62 days pay for each subsequent year's service. In the case of Lieutenant this equals £86 16s. In the case of Captain this equals £96 2s. (*Note.*—A T.C. Officer gets £60 at the end of each year).

4. A T.F. Officer joins a Unit and cannot be drafted to another Unit without his sanction. (*Note.*—A T.C. Officer is only attached to a Unit and can be drafted at any time to any other Unit without his sanction).

The following is a table showing Pay and Allowances (Daily Rates):—

LIEUTENANT—	R.A.M.C. (T.F.) At Home.	R.A.M.C. (T.F.) With E.F.	R.A.M.C. (T.C.) At Home or with E.F. Consolidated
Pay	14/-	14/-	Pay, 24/-
Field allowance	3/-	3/-	None
Lodging, light, and Fuel Allowance	—	3/-	None
	17/-	20/-	
Gratuity, after one year, £86 16s.			£60

CAPTAIN—	R.A.M.C. (T.F.) At Home.	R.A.M.C. (T.F.) With E.F.	R.A.M.C. (T.C.)
Pay	15/6	15/6	Same as for
Field allowance	3/6	3/6	Lieutenant.
Lodging, light, and fuel allowance	—	4/-	
	19/-	23/-	
Gratuity, after one year, £96 2s.			£60
" " two years, £48 1s.			£60

Free rations are issued in each case or an allowance in lieu.

If any gentleman wishes to join I shall be only too glad to see him—if he will write and make an appointment—and give him any further information.

But men are urgently needed, Sir, in order to train them for the work, and because we are hopelessly understaffed.—Yours faithfully,

"Kirkella,"
Sevenoaks, Kent.
October 29th, 1915.

N. E. ALSTON, Major,
Officer Commanding 2/2nd H.C.F. Ambulance, R.A.M.C. (T.)

Papers by Guy's Men.

E. C. Hughes, M.C., F.R.C.S.: Diagnosis of ulcers on the tongue. A Clinical Lecture at Guy's Hospital.—*British Dental Journal*, Nov. 1st, 1915.

R. H. Jocelyn Swan, M.S. Lond., F.R.C.S. Eng.: Gunshot injuries to peripheral nerves.—*The Lancet*, Nov. 13th, 1915.

Queen Mary's Royal Naval Hospital, Southend.

Her Majesty Queen Mary's Royal Naval Hospital, Southend-on-Sea, has been so very largely helped from Guy's that, perhaps, a very brief account of a year's working will interest our readers.

Soon after the outbreak of the war a committee was formed to acquire for a consideration the Palace Hotel, Southend, for the duration of the war. This was done; over £22,000 was subscribed, and the hotel was converted into and furnished as a hospital, Her Majesty graciously becoming Patroness. More beds have been recently added. and it now contains 300 beds. It has been unreservedly placed at the disposal of the Admiralty and the War Office. The first patients were received in October, 1914, and during the first twelve months of its existence over 2,000 patients have been admitted into the hospital, mostly soldiers from Flanders, but one convoy consisted of wounded Belgian soldiers and another of Royal Marines from the Dardanelles.

The maintenance average per patient per day has been 4s. 7¼d. If the cost of administration is added, this becomes 4s. 9½d., and if to this rates and taxes are added, this becomes 5s. This is (apart from the initial expenses of equipment, which amounted to £2,537) the total daily cost of each patient, and this figure compares very favourably with that of other large hospitals.

Messrs. Jackson, Pixley, Browning, Husey & Co., the auditors, in their report at the end of the financial year express the opinion that "the financial conduct of the Institution is very well looked after, also that the books of account, etc., are in the hands of experienced and responsible persons, and not amateurs, as is generally the case in most charities which have sprung into existence during the war." After making this quotation it is only fair to state that the accountant to the hospital is Mr. H. J. Hansford.

Since the hospital opened in October, 1914, the following from Guy's have helped :—Chairman, Dr. Hale White; Visiting Surgeon (first four months), Mr. R. Jocelyn Swan, subsequently Mr. E. C. Hughes; Visiting Ophthalmic Surgeons. Mr. A. W. Ormond, then Mr. H. L. Eason, now Mr. R. A. Greeves ; Visiting Surgeon for Diseases of the Throat and Ear, Mr. W. M. Mollison; Physician for X-ray Department, Dr. E. C. Iredell; Resident Medical Officers, Dr. R. A. Chisolm (for the first year), now Messrs. Evelyn Scott and Sells.

Matron, Miss Kate Finnemore. The following Sisters trained at Guy's are now working :—M. E. Blott, M. J. Ferdinand, Edith Hope, G. Jenkins, K. Krauth, A. Maycock, Lily Purves, E. Latham, R. Salter, A. M. Smith, M. E. Vanes, M. West, Lily Wood, J. Knight Law (masseuse), F. Ryan, and M. Fraser.

The following from Guy's have worked at Queen Mary's, but have left recently : — S. Browning, F. Brooks, C. Edwards, E. Naylor, C. Snelling.

Appointments.

Royal Army Medical Corps.

The following appointments have been notified :—

Temporary Major J. F. W. Silk to be Temporary Lieut.-Colonel.

Major Arthur F. Hertz, R.A.M.C., c/o Director General of Medical Services, Alexandria, has been appointed to the Medical Advisory Committee (Prevention of Epidemic Disease), Mediterranean Expeditionary Force.

The undermentioned temporary Lieutenants to be temporary Captains:—P. J. Watkin, W. T. Channing-Pearce, W. E. Wallis, H. G. Rice, T. P. Cole, A. S. Taylor, J. H. Campian, W. G. Brett.

To be temporary Lieutenants:—A. M. Webber, J. Black, B. H. Palmer, J. O. Garland, R. P. Marshall, H. D. Wyatt.

"As I believe you like to hear of promotion amongst old Guy's men, mine is from temporary Lieutenant to temporary Captain" :—G. Frank Hardy, M.O., 23rd Brigade, R.G.A., B.E.F.

Arthur H. Spicer, Esq., M.R.C.S., L.R.C.P., late Assistant Physician at the King George's Hospital, has taken a commission for General Service in the R.A.M.C.

Territorial Force Reserve, R.A.M.C.

London (City of London) General Hospital:—E. C. Hughes and F. D. S. Jackson to be Captains, whose services will be available on mobilisation.

London Field Ambulance:—E. P. Minett is restored to the establishment.

Welsh Border Mounted Brigade Ambulance:—W. Morgan to be Lieutenant.

London (City of London) Field Ambulance:—Capt. A. D. J. B. Williams relinquishes his commission.

Attached to other than Medical Units.

Major H. P. Berry, from attached to Units other than Medical Units, to be Major.

Civil.

F. M. Holborn, Esq., L.D.S., Cumberland Lodge, Streatham Hill, S.W., has been appointed Dental Surgeon to the Tooting Military Hospital.

Honours.

D.S.O.

The Distinguished Service Order has been awarded to Captain (temp. Major) John Wilfred Bird, R.A.M.C. (T.F.), 6th London Field Ambulance.

For conspicuous devotion to duty during operations at Maroc and Loos, between Sept 25th and 30th, 1915, in dealing with casualties. On one occasion he worked for 23 hours without any cessation in dressing and tending the wounded. He set a fine example which had far-reaching results.

Mentioned in Despatches.

Lieut.-Colonel L Humphry has been mentioned in a despatch from Sir Ian Hamilton, dated Sept. 22nd, in connexion with operations in the Dardanelles.

Capt. B. H. Wedd, R.A.M.C., 23rd Field Ambulance, B.E.F., France.

Rugby Football.

GUY'S v. H.A.C., 2nd Battalion.

There was a very strong wind at Honor Oak Park for this match last Wednesday, November 10th, which prevented any accurate play. Many passes went astray, and the biting wind numbed one's fingers so that the ball was difficult both to receive and pass.

The soldiers came with quite a useful side, though their two best forwards, Lieutenant Macgowar, who used to play for the London Irish, and Lieutenant M. Spicer, a very prominent Old Millhillian forward. Rainer, of the O.M.T.'s, was a visiting half-back, and many other Public School men were in the side, as well as our old friend and opponent of many years, Sergt. Francis Heedy, the old Kent and Catford player.

It was pleasant to see H. Millett back again, looking well after his recent serious illness. He very kindly refereed. Millett, who is a Lieutenant in R.M.L.I. has been serving, until his illness, with British Mediterranean Force in the Dardanelles.

In the first half Kidman scored for Guy's and Medlock converted, then Medlock got over for a certain try, but had the ill-luck to lose the ball. For the visitors, Dudley gained the try, and Helder put on the major points. This was all the scoring all through, and about represents the merit of the teams, though had Kendall a bit more pace and ability to clear his opponents by feint or swerve, he would be of infinite use to his winger. Knott often came into possession too late, or found himself waiting, well placed, for the pass that never came. McEvedy was very safe. Leviseur quite good. While Kidman, Armstrong, Reitz and Watson were the best of a good pack. Guys, 5. H.A.C., 5. Team:—

P. J. McEvedy (back); F. A. Knott, E. A. Leviseur, N. E. Kendall, C. L. Curle (three-quarters); C. Becker, C. H. Medlock (halves); G. F. Kidman, A. W. A. Davies, A. W. Armstrong, P. Reitz, L. K. Watson, J. G. Gie, J. Joffe, — Hawes (forwards).

GUY'S XV. v. R.M.A., WOOLWICH.

For this match at Woolwich on Nov. 6th, we had our usual side out, but the Academy were not very strongly represented. Many of the players had only come into residence the same week, so that combined practice had been practically nil. We had the advantage of the slope to commence with, and quickly getting the backs on the move Blacklaws was sent in for a try by Medlock rather wide of the posts. The Academy adopted our tactics, but they had the slope against them and their passing was so slow that all attacks were bottled up and we returned to the attack successfully, Kidman scoring for Reitz to Majorise. A very fine piece of work brought the first half to a close. From a scrum close to the R.M.A. line Becker passed to Medlock who dashed round the blind side and put Knott in very neatly. No goal resulted and ends were changed with Guy's leading 11 points to nil.

Resuming, Leviseur, who played exceedingly well all through, dashed through and passed to Knott, but Bishop grassed the winger when almost over. Knott, however, was successful just after, Medlock throwing wide and Knott accepting he cleared round behind the posts for Reitz to add the further points.

The Academy left three-quarter was hereabout very prominent with some determined runs, but he was well held by McEvedy, and Guy's reviving Reitz scored an unconverted try. Baker, for the home side, kicked an excellent penalty kick, but it fell just wide, the same player made amends just after, however, by scoring the Academy's only try. Knott scored once again, but as no conversion followed, the final score read Guys, 24 (3 goals, 3 trys) to 1 try.

The Hospital was short too-thirds of the game as Whitcombe had to retire with a damaged eye. Team:—P. J. McEvedy (back); F. A. Knott, N. E. Kendall, E. A. Leviseur, G. Blacklaws (three-quarters); C. H. Medlock, C. Becker (halves); G. E. Kidman, A. W. A. Davies, D. W. Whitcombe, P. Reitz, C. W. W. Armstrong, L. K. Watson, J. Joffe, J. G. Gie (forwards).

Births.

WARNER.—On the 4th inst., at "Rydal," Woodford Green, the wife of Harold P. Warner, M.B., B.S., of twin sons.

FOTHERGILL.—On Nov. 2nd, at Calverly Crescent, Tunbridge Wells, the wife of C. F. Fothergill, Esq., M.B., B.C. (temp. Lieut. R.A.M.C.), of "Hensol," Chorley Wood, of a daughter.

Marriages.

POLLARD—FRASER.—On Nov. 12th, at Moffat Parish Church, Dumfriesshire, John McFarlane Pollard, West African Medical Staff, to Mary Campbell Fraser.

CHISOLM—NAYLOR.—On the 10th inst., at St. Paul's Church, Weymouth, by the Rev. Canon Myers, assisted by the Rev. Martyn Fisher, Robert Alexander Chisolm, M.A., M.D., Oxon., younger son of the late William Chisolm, of the P.O.S.N.Co., and Mrs. Chisolm, of High Wickham, Hastings, to Alice Maude Eleanor Naylor, eldest daughter of the late Thomas Edwin Naylor and Mrs. Naylor, of Cambridge.

F. A. K.

GUY'S HOSPITAL GAZETTE.

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Passim.

AN inherent power to withstand the storm will ever be found in the constitution of our great hospitals, and we have to-day the beginning of one of those manifestations in which all, from the highest to the lowest, will feel—the strong and yet tender embrace of the indefinabfe spirit of old Guy's. December comes, and our woes and worries are slowly changed in proportion; and whilst the month wears on, their attacks seem to lose in intensity and persistence, until we find them buried and forgotten beneath that monument to love and good-fellowship—Christmas.

Many a question may be still unanswered and many wrongs unrighted, but, as always, Christmas at Guy's will bring joy and respite to all within our walls and a welcome to all who chance to return to the paths they have so many times trodden.

WITH the coming season of perhaps less active operations there appears a further opportunity of thanking the many of our friends on service who have spared us their time and thoughts, and even for again making an appeal to the many who have only just failed to carry out their intentions, Topics for discussion are nowadays so scarce and devoid of the old-time variety that letters from the many seats of operations in which Guy's men must now find themselves will be more than welcome to readers of the GAZETTE.

IT is with deep regret that we read of the death of Lieut. H. Hogben while serving with the Expeditionary Forces. We offer our sincerest sympathy to his relatives and friends.

WE are glad to learn that there is a very decided improvement in the College catering arrangements and the food supplied. Details of the cause and means which brought this change about are not in our possession, but having taken a step in the right direction, we would urge that all—those catered for as well as the caterers themselves—should do all in their power to further the improvement by the exhibition of the maximum of mutual consideration.

IT is somewhat disappointing to again hear of a constant lack of consideration on the part of some few dressers in the out-patient departments and surgeries, particularly at the present moment, when time and illness, as we hope only temporary, has further depleted the ranks of the qualified officers.

IN conclusion, we must express an unqualified apology for the present number of the GAZETTE. It seems doubtful whether at any previous time there has been a greater shortage of copy or a greater difficulty in obtaining it. May we appeal to Guy's men, past and present, to aid us in this matter? As many splendid thoughts and as many exceptional cases must be amongst us as in the old days, and requiring only that irksome but essential effort from the man behind the pen.

The Dental Society.

THE first meeting of the new term was held on the 19th October, when Mr. L. D. Wright gave his inaugural address as President for the ensuing year.

Gentlemen,—We meet to-day at the beginning of another academic year, and on such an occasion it is usual to discuss the events of the past year and what we are to do in this. Before doing so, however, I wish to thank you most sincerely for the honour you have conferred upon me. To find myself elected President of the Dental Society of Guy's Hospital was no small surprise to me. I take it as a compliment and courteously thank you for it.

I have always felt that it is the duty of the junior members of the Staff to attend this Society's meetings. Why? for several reasons. It is essential that members of the Staff and students of this hospital should work together in perfect unison that they may keep up the great tradition of the hospital. To this end we should become acquainted with one another as much as possible, and a very good opportunity is afforded us in these social gatherings.

When I found myself back at my old School as a Demonstrator, I set myself the task of gaining, firstly, self-confidence, then of knowing all the men of the School and getting them to know me, and finally winning their confidence. To help me to reach this pleasant ideal I attended your meetings last year, but I little thought that I should in such a short time so far obtain my object as my position here to-day seems to show. It gives me infinite pleasure to be here, and I hope with the help of my secretary we shall have an interesting and successful year.

Now, gentlemen, you are aware that very great things are happening in the annals of the dental profession. The importance of the creation of the Army Dental Surgeon's Commission must appeal to you. It is the public recognition of the importance of our profession. We also see with satisfaction, but more with amusement than pride, the refusal to accept unqualified dental assistance in the army. These things should stimulate us to harder work and greater interest in our work. I therefore wish to appeal to each one of you to help to throw life and interest into the work of this Society, the more social side of your hospital studies, for you come here to learn.

Last year the meetings, though well enough attended, brought forth little discussion, and you see it has not been thought fit to award the prize for the best paper. Now, I do not wish that to occur this year. I have expressed myself willing to your committee to add another guinea to the offered prize. I shall put before you a set of four papers to be written, I hope, by the majority of you, and the best paper on each subject will be read at the meetings. The prize will be given to the writer of the best set, and in this way you all stand a chance of securing the prize and reading a paper. This is to try and arouse interest and discussion; we shall have present at the meetings several or many who have read up the subject and can express their views. I also call for as many casual communications as can be brought along. In this way we shall further our knowledge in the pleasantest possible way.

I have tried, gentlemen, to get together a record of the doings of our men in the war, but I have found it an impossible task. Let us offer Captain Fry our congratulations on his decoration, and may we have the honour of having him as President in the near future. Many only too valuable friends have gone; let us say no more of them, but feel much.

An animated debate followed on the "Efficacy of the Dental Syllabus." The meeting finally adopted a resolution to the effect that the dental branches of the following subjects should be more fully studied and also that they should be included in the dental examinations: Materia Medica, Bacteriology, and Radiography; also that Prosthetic practice should be carried out during the whole hospital course. The papers suggested by the President and approved by the committee were as follows:—

1. Discuss for your patient the treatment you might adopt in dealing with a case of early, marked pyorrhœa alveolaris.

2. Fused porcelain work in conservative and prosthetic dentistry.

3. The treatment of children in private practice.

4. The difficulties met with in the operation of extraction, and after, and their treatment.

The Society's prize for the best set is £5, the first paper to be handed to Mr. L. D. Wright before the 16th November. The President and committee appeal to members to loyally support their efforts to make the meetings both a social and a technical success.

Papers by Guy's Men.

R. H. Jocelyn Swan, M.S. Lond., F.R.C.S., and K. Goadby, M.R.C.S., L.R.C.P., D.P.H. Cantab.: On the recrudescence of local sepsis in completely healed wounds.—*British Medical Journal*, Nov. 22nd, 1915.

G. H. Hunt, M.D. Oxon., M.R.C.P. Lond. (in collaboration with A. C. Rankin, M.D., D.P.H., McGill): Intermittent fever of obscure origin occurring among British soldiers in France.—*The Lancet*, Nov. 20th, 1915.

C. Norman Meachen, M.D., B.S., M.R.C.P.: Dermatology and the War.—*Universal Medical Record*, October. 1915.

L'espion Malgré Lui.

I.—THE CAPTURE.

This aforetime was a paradox, but now the war gives it proof.—HAMLET.

". . And those in the ship bound me upright, hand and foot, to the mast, and fastened the ropes from it, and they sat down and smote the hoary sea in long sweeps. But while we plunged swiftly on and came as near as a shout might travel, not secretly they rose up hard by the sea-swift ship singing this clear song. 'As thou goest, Odysseus, Lord of the Achaians, here bring thy ship to land that thou mayest hear the speech of us twain. For there be none that have sailed by in their black ships but have heard the honey-dropping speech of our mouths and gladly have dwelt here gaining greater knowledge.' . . So spake they sending forth lovely speech, and straightway my heart yearned to be heard and I bade my fellows loose me, bending my eyebrows at them for a sign. But they leaning to the oars, rowed the harder."

There was no particular excuse for my making a fresh version when there are so many excellent translations on the market, but I wanted to express an exaggerated regard for this island without writing sloppy dithyrambs. And, of course, Capri is the island of Syren. Have you not seen on the guide books an unpleasant half female creature intended for the Homeric syren. Old Homer, the "Ionian father," that "mouth sweeter than Calliope's," etc., knew his business when he planted his colony of Syrens on these shores. There may or may not be some truth in a complex yarn I once heard of someone who knew someone else who knew a Frenchman who had written a book to prove that Homer had a Phœnician chart at his elbow when he wrote the Odyssey. Anyhow, he could never have found a place more happy for his purpose. The island lies off the Sorrento end of the Bay of Naples. Anyone coming from the Gulf of Salerno towards Sorrento would have to pass by close to Capri, and those sea-weary heroes with their "old Greek dread of the sea" would yearn to land on the little sea beach and forget their toils. I do not see how Odysseus got his men to row past; it only costs 20 centesimi to land at the *Marina Grande*, and to this day the boatmen sing you songs about the Syrens.

Guarda attuorno sti sserene!
Ca te guardano 'ncantate
E te vonno tantu bene,
Te vulessero vasà.

Which, translated out of the abominable Neapolitan dialect, runs: "See around the Syrens who watch as if enchanted, and crave a kiss, so much do they love you." Almost as bad as the hotel visitors' books, where honey-mooning Italians flaunt the Muse: "Addio bella Sirena, addio bellissimo cielo, addio . . etc."

After the Odysseus incident the history of Capri remains sufficiently vague for a thousand years or so. One likes to think of Greeks from the sea-golden city of Poseidon (Neptune) down in the Gulf of Salerno coming to enjoy the cooling airs after a spell of *scirocco*, perhaps Phœnician traders established the cult of Mithras, God of the Sun, in the cavern high up on the cliffs where years ago his gilded image was discovered. In 26 A.D. the Emperor Tiberius retired to Capri to consider his past actions in the vain hope of discovering some new brand of debauch. Having built twelve palaces (you can see the remains of one perched high up on the eastern heights) he seems to have passed his time in rushing madly from one to the other. Apparently it never occurred to him that a quiet and blameless existence would have been the last and sweetest of perversions. Since then the island has been the literary (and actual) scene of many disgusting orgies and their consequences, like the syphilitic bastard in Flaubert's "Hérodias," and the hero of Dorian Gray's novel who "tells how, crowned with laurel lest lightning might strike him he had sat, as Tiberius in a garden at Capri, reading the shameful books of Elephantis, while dwarfs and peacocks strutted round him, and the flute-player mocked the swinger of the censer."

At present the island is, or was, devoted to the German tourist and his works, and the walls are everywhere plastered with German names and little couplets which I have every reason to believe scurrilous, happy evidences of the sportive Teuton. However, by the time we arrived the war had had its usual purging effect, and the last German had left amid much popular hostility and stone-throwing some days before. Indeed, the more enterprising of the fisher lads had pulled down the diminutive steeple on the German church owing to its supposed resemblance to the peak of a Tedescan helmet. So that the little terraced piazza where the German-built funicular railway from the harbour ends, was empty of its usual crowd of tweed-suited, Bædekered tourists, and the arrival of two such insignificant people as my friend and I caused a lively stir amid the assembled loafers and cab touts. Touring in Italy this year has been a curious experience. One feels, as, indeed, one felt in Paris last September, rather like a schoolboy left to wander round the school buildings when all the rest have left for the holidays. Except for one or two English spinsters to whom Italy has become a second home, all the hotels are empty, inevitable Americans and æsthetic maidens from the London suburbs are not, and the supercilious and arrogant hotel managers suddenly transformed into human and obliging individuals, ushering you into regal suites and vault-like dining-halls with gestures of exaggerated respect. Even the beggars, who in Southern Italy are counted among the

more prosperous members of the community, have been forced in many cases to take to work, and not a few I was told, had enlisted under the colours.

A beautiful place, this Capri, and small wonder that Wells puts the pleasure city of "When the Sleeper Wakes" within its happy shores. Very beautiful flowers grow on the hillside; yellow broom and coronella, and a spiky yellow gorse, blue crocuses (late ones), thyme, and a shrub with a leaf like rosemary, and blue flowers, narcissus, and bee orchids, blue-red anemones, and a kind of white heather. Up on the hills the olive trees show dark and wise in the sunlight, and all the slopes are green and lustrous with terraced lemon and orange. One sees queer birds, too, like quails and hawks, and, I think, ortolans. And around the flowers fly the honey-bees and yellow butterflies and fritillaries, sometimes a swallowtail poises by one. The Blue Grotto, beloved of the poet-aster and the post card vendor I did not see, much more wonderful was the *Grotta Meravigliosa* where after an arduous climb on slippery rock, you are rewarded with a sight of elf-like beauty. A great arching stalactite cavern, perched fifty feet or so above the sea, but illuminated from it through a small aperture where the light shines in shifting emerald and ultramarine, fading away into utter darkness, the roof and sides veiled in shadow, with here and there a crystal gempoint. Great boulders lie scattered like giant *débris*, and a tiny pebble flung at random raises mighty echoes. Wonderful, too, is the winding road to Anacapri, the rival township to Capri perched high among the sterile rocks by Monte Solaro, with its shifting vistas of the lower island, the Bay of Naples, and the Gulf of Salerno. There a thousand feet below lies the unflecked mirror of the sea, so marvellously clear that the ruins of a Roman villa long since engulfed are clearly visible in its depths, Vesuvius lying at the base of that great falciform sweep which begins at Sorrento and sweeps round to the rocky islets of Ischia and Procida. Away opposite us stretches the white line of Napoli the accursed, shining in a meretricious purity and faintly obscured by the mist is Cape Miseno where young Misenus the trumpeter, as Vergil tells, was buried in martial pomp. The Bay is empty save for one rusty tramp steamer ploughing its way across to the harbour of Castellamare, and the white cap of Vesuvius is fallen low with the promise of coming *scirocco*. Up in Anacapri the houses remind one curiously of Pompei. The streets are narrow, twisted lanes, and many showing only a blank wall with, perhaps, one window to the road. Inside they are built about a kind of open court, and a garden very like the Roman *atrium*, and when, as one often sees, there are two or three white columns set up for a vine or wisteria the resemblance is extraordinary. I suppose it is quite possible for a tradition of Roman building to continue unchanged by prevailing fashions in a spot so remote as this.

It was after three days of bathing and climbs in the early morning sun that the disaster befell. We had been talking, I remember, to a garrulous old Englishman, one of those queer derelicts that one often meets abroad in places frequented by the tourist, the presiding genius of a general store where you could buy Kodak films and Gold Flake cigarettes and the Continental Daily Mail, and horrid little sketches of a rascally white-bearded loafer who hung about the shops where his degraded countenance was displayed. Little thinking, I had told him of some minor experiences in France at the outbreak of war, arrests and passport difficulties such as happened to most of us who were abroad at the time. The incident would be without significance were it not for the importance it took in subsequent events. We bathed and fished, then, after a somewhat copious lunch, which led my friend as he retired for the *siesta* to remark that enough was as bad as a feast, I proceeded, armed with a camera, to explore the island on my own account. Chance led me to the Via Krupp, an artificial roadway made at enormous cost by the late Herr Krupp, which commands some of the finest views of the seaward side of the island. The hour was late afternoon and the little seats and pleasaunces which are here and there cut out of the rock were thronged with people. At the highest point of the road, a little *piazzetta*, I stopped and, producing my camera, proceeded to take one or two snapshots of the coast and town.

The idlers on the seats apparently took no notice. About 40,000 foreigners visit Capri per annum and it is reasonable to suppose that at least 50 per cent. take snap-shots from the Via Krupp. They'd be silly if they didn't. But I had, alas! mistaken the psychology of the Italian people. Though your island may be visited every year by 25,000 Germans, and photographed, sketched and painted *ad nauseam* by every one of them without let or hindrance, yet the moment war is declared the photographing of a view to be found in every post-card shop in the island, or for that matter in Naples or Rome is an act to be viewed with grave suspicion. The Italian mind declines at once to believe the obvious and in war time as of course in every other country each foreigner is a potential spy. Happily enough I proceeded back to my hotel for tea and it was not until I reached the centre of the town that I realized something was amiss. Then as I was peering curiously into a shop window filled with belated German *delicatessen*, a hand tapped me on the shoulder and turning round I saw a dusty soldier very much out of breath, the vanguard of about twenty others who, to judge by their equipment had just been summoned from a deep sleep. "Will you just come along with me for a moment, *Monsieur*," he said in broken French, "the *Questura* has one or two questions he would like to ask you?" By this time the rest of the cohort had arrived and a huge crowd had gathered. There were threatening murmurs, "*Una spia austriaca, . . . a lanciato le bombe*," etc., and by the time we set off to the *Questura*

things began to look fairly ugly. Down the narrow alley which is the main street of Capri the mob were kept back by the soldiery (they had their uses after all), but my temper was not improved by a stout individual suffering apparently from severe asthma, who announced himself as the mayor or vice-mayor of Capri or Anacapri, I forget which, and tried to cross-examine me in about four languages including German and a jargon that sounded not unlike Russian. My previous experience of Southern Italian justice (*vide* GUY'S GAZETTE, July 17th) had taught me the uselessness of replying to anyone, so I answered not a word. This I subsequently found was a point which had raised the gravest suspicions—I was held to have been engaged in fabricating a plausible story! Arrived at the Questura, matters appeared for a moment to be assuming a more reasonable aspect. The *Questura* himself, a mild little man, apologised for the inconvience to which I had been put, but, said he, I must understand that in these exceptional times no precaution was excessive, and as soon as my photographs had been developed he would no doubt be able at once to release me. He hoped, indeed, that this evening I should have the pleasure of joining him in a cup of coffee, when we should both laugh over this trifling affair—*questa cosa di niente.*

Just at that moment, however, a hubbub was heard on the stairs and a choleric personage, immensely fat, and clad in a sort of glorified policeman's uniform, bounded in, followed by a posse of *carabinieri* armed with bayonets and muskets. "This fellow," he said, pointing to me as I sat chatting amicably in the *questura's* armchair, "is an Austrian spy who has thrown six bombs." Then to me, "Stand up and show respect to an officer of the law!" Events afterwards followed a little rapidly. I stood up and was promptly seized from behind by two *carabinieri.* Breaking loose, I made a tentative jab at the luscious abdomen of the *maresciallo*, uttering meanwhile, so the interpreter assured me afterwards, atrocious blasphemies in Montmartre-French; luckily all my Italian left me. Then more men stepped forward, and I was collared and bundled into a corner, swearing freely, while the maresciallo, a little purple about the ills, went through my pockets. After that there was a long and ominous colloquy, of which I could only istinguish a word here and there—"*Sé mostrato molto Ribello . . . per lo spionaggio . . . carcere. . . .*" It was clear that I had prejudiced my case. Then fresh arrivals. My friend, who speaks Italian so well that he is always mistaken for a German, and the English Vice-Consul, followed by a couple of flea-ridden terriers. An instant change of front. I am an Austrian no longer, but an Englishman who has committed a simple imprudence; the spleen of the English is well known, their eccentricity, their fabulous wealth. Of course, that was it: I was a "*Signore molto ricco, dilettante appassionato della fotografia.*"

For a while things veered round in my favour. The *maresciallo*, it is true, still eyed me with resentment, but the *questura* represented the matter as the merest formality. "Just till the photographs are developed, *Signore*, then as soon as we have satisfied ourselves that they are not points of strategic importance you can go with Signor —— (my friend) and will doubtless relish your dinner the more for this little interlude." Peace was restored and we fell talking of the latest Italian victories (there was a fresh one every day) as became good patriots and loyal Italophiles. After a while the negatives arrived, brought by no less a person than the Englishman with whom we had talked that very morning. I was confident, nonchalant. "See," said I, "they are of exactly what I told you. the Faraglioni (a series of pointed rocks, standing out from the shore, much as do the Needles) and the Certosa (a disused Benedictine Monastery). "Yes," said our Englishman, "But don't you know that the Certosa only two days ago was made the barracks for the Territorials who are stationed here, and the Faraglioni also includes the *Semaforo.*" Sure enough in the corner of the plate was a black smudge which was undoubtedly the little semaphore station I had seen perched high up on the cliffs, and as for the Certosa being the barracks for the fifty or so broken down Territorials whom one noticed slouching round the island and haunting the drink bars, it might as well have been the royal palace or a model dairy for all I knew or cared. Huge excitement in the conclave, messengers despatched to the commander of the garrison (sic) and the captain of the *Semaforo.* The *maresciallo* jubilant tells the *questura* that he knew it all the time and signs to two *carabinieri* who enter and stand one at the window and one at the door. The Consul and the rest of us are vaguely explanatory, the crowd outside the window begins to murmur angrily. Presently the commander of the garrison arrives, a scrubby little lawyer, second lieutenant of reserve, whom I recognized as having travelled over on the same boat as myself. He is full of legal technicalities and produces from his pocket-book a newspaper cutting of a law which nobody had heard of, by which I find I am liable to three years in prison and a fine of 4,000 *lire*, After him the commandant, a fierce naval personage, with great *empressement* he examines the negatives upside-down. Yes, undoubtedly, it is the semaphore. At once he smells a plot; I must have discovered that important alterations had recently been made (I found afterwards that a new tank for water had been constructed six months before); moreover Capri, and this especial spot in Capri was the most important strategic point in the Mediterranean. Then this Englishman joined in: Did they not know, said he, that I had already been arrested and imprisoned at Salerno, and in France I had been repeatedly arrested and finally expelled from the country. In vain I pointed to my passport in perfect order, my permit of residence at Naples, my cards from the Red Cross, the unimpeachable respectability of my friends. With expressions of profound regret, handshakings, and promises of a speedy release, the *questura* informed me that the matter must be looked into, and referred to a higher authority than his. "A day, two perhaps, and the matter

will no doubt be satisfactorily settled, but in the meantime the Signor must be patient and remember that he has been, let us say, a little indiscreet." So with perfect politeness and suavity I was escorted out between two gendarmes and followed closely by my friend, the Consul, and the two dogs. The populace, face to face with a happening of such gravity, were silent, almost subdued. As we trudged back along the little street, I said with almost prophetic insight, "I bet I'm in for a couple of months," an underestimate as it turned out. Then we entered a dark archway, there was a scraping of keys and a whispered conversation through a spy-hole. I was ushered into a little courtyard, and the gate closed behind. My long imprisonment had begun.

G. H. F. G.

Letters from Guy's Men on Active Service.

From a Naval Surgeon in the Mediterranean.

Things out here are very much the same as when I wrote to you last on the 25th. By the way, I have written to you this month, according to my mail book, on the 3rd, 7th, 12th, 18th and 25th, so you will see what are missing. Your geographical lecturer was quite right in a way, and in a way he was wrong. We had won our way through here on February 25th, March 18th, April 25th—28th, and August 6th. Each time the thing was done, and with a few more men we should have been through in February and March, 3,000 men landed would have done it. In April, 18,000 more men pushed ahead on the evening of the 28th, and we were through on August 6th: the men to do it were actually landed. . . . . Even now there are a very large number of people who think we could still do it if the worst came to the worst, but with enormous losses of ships and men.

We are lying at Imbros and appear to be going to remain here indefinitely, absolutely safe and fairly interesting. We are doing senior naval officer for all the myriads of small craft, trawlers, sweepers, drifters, tugs, etc., that supply the beaches, and particularly Suvla, with stores and ammunition. We are the postal sorting office, every letter out is censored and sorted and despatched to Mudros for carriage home, and the mails from home go first to Mudros and then on here, where they are sorted and distributed. I have a good deal of that to do, especially the censoring. Then every morning the wireless news is brought to me and I make an enormous number of copies, it varies between 50 and 130, and give them to the mail office for distribution. All the sick and any accidents which occur in any of these smaller ships are brought to us, and we have in addition to examine and survey all the men from the fleet and from the three wings of the Naval Air Service who are going to be invalided home for any reason. It is just general organisation that we are doing—no fighting at all—and we shan't do any at present nor move out of harbour probably till we come out to come home.

I am glad you don't mind my ranting occasionally—I feel cheery to-night so you won't get it in this letter—but I have to keep cheery when writing to men and in the mess here. We have enough pessimists as it is, moaning all day, and we younger ones have to stir the others up, but the worst pessimist of the lot is quite cheering up, and he actually laughed till he cried the night before last when I was trying to demonstrate the fireman's lift on Lieut. D. D. is 6 ft. 3 in. and weighs nearly sixteen stone, and I'm bothered if I could lift him, so we decided nobody would ever win the V.C. with him. I could just manage to pick up a limp pseudo unconscious B. who weighs about twelve stone, and stagger out of the mess with him—but I would'nt like to try it under a hot fire.

I really am beginning to think that Germany is done. This last raid is her "swan song," if she succeeds she may gain an additional nine months of life, if she fails she is finished and the finish will come quickly.

When it was finally decided a few days ago that we were going to remain here permanently, the Commander and I put our heads together and I went ashore that afternoon and surveyed the only more or less level patch I could find, and the next day the Major of Marines and I went again with his servant and mine to help to carry, and we took flags and posts and a crowbar —and behold—a nine hole golf course, and now everybody goes ashore on every opportunity. The Commander and the Chaplain had clubs. I had three balls, and the other two five or six each, and the improvement in the temper of the mess is extraordinary. We have sent to Malta for a few more clubs and a couple of dozen balls, so far no balls have been lost, but we search with considerably more persistence when one goes astray than we ever should at home, for balls are valuable when you've only a dozen or so, and no reserve for a month. To-morrow I am going ashore at 8.30 a.m. with 70 marines to level and burn the shrub and make bunkers and generally clear up, and this afternoon the captain of the surveying ship gave up his only afternoon off to survey the course and draw a map, which was extremely good of him.

To-day has been Sunday—quiet, as usual, with Captain's round and Church in the morning—and sleep or a walk in the afternoon and Church again at 6. I played the organ as usual, and this morning's hymns were delightful, and to-night we had "The day thou gavest, Lord, is ended." If you want to hear that sung, come and listen to 100 blue jackets (it's a voluntary service, not official, like the morning one) lifting the roof off. They can sing, those men, but they will have their own speed and their own pauses; it's useless to try and lead them, for they won't listen, and it's very difficult to follow them, but away goes the hymn, and, willy-nilly, you follow them, till somehow the quaint

pauses grip you and the original seems meaningless and machine-like, and after about three verses I give up the music, just keeping them in tune and sing with them with all my lungs. L. C. D. I.

M.E.F.,
39th Field Ambulance,
13th Division,
Suvla Bay,
4th Oct., 1915.

I have been having what might be called a fairly exciting time out here. We have been out here for over three months, and out of ten M.O.'s who first came out with the ambulance only myself and two others are left and I am running the show, whilst there are considerably less than half the crowd that we came out with and of those that are left very few are in a fit condition to carry a stretcher more than a mile. We have taken part in every scrap of any importance since we arrived, and the whole time we have been here we have never been out of range of shell fire or even bullets, not quite the thing that is laid down in regulations for a field ambulance. However, I am still running about as full of life as ever. I have come across one or two Guy's men out here: Symons, Galloway, York-Moore, who, by the way, has got typhoid and has gone home. Harkness is out here too, but I have not yet come across him. I suppose you have heard that I have been awarded a Military Cross. I am rather pleased because it shows that a mere civilian can be as good as a regular in spite of all their swank.

At the present moment things are fairly quiet and I am running a small hospital of about a hundred dysentery cases. I shall be quite a specialist in that line if I can get out of this. At present the only way of accomplishing that is to get it oneself or else get in the the way of a bullet, the disadvantage of the last being that it is rather hard to choose the best portion of one's anatomy to be punctured. There have been several occasions in which I have had pretty close shaves, but, however, a miss is as good as a mile. One is so cut off from the world out here; I have had very few letters from anyone.

On the whole, the Turk fights very fairly, but there have been times when he has kept us very lively by throwing a few shells into the hospital. I don't think they are really intentional, but that is poor consolation to the man who happens to be in the way. But still one must give him his due.

At the present moment we are just off the beach and have a fine view of the surrounding country. Occasionally a shell will pass overhead, to or from the ships in the bay, but the troops are carefully entrenched on both sides and surrounded by wire and take very little notice of each other. In fact, at times one would not know there was a war on, as one can walk singly or in any number less than four straight across the open from our place to the trenches and no one deigns to fire a shot at one, but if a small mob does the same thing, then there is trouble.

One of the great nuisances of this place has been the number of flies there are about, they amount to more than a plague. At one time it was a toss up which would have the greater part of the rations, you or the flies. You had to eat with one hand and drive them off with the other. Then there was *some* heat and little drink. Oh, visions of long iced lemons, and so forth, especially when we were upon the bare hillside with no shade at all, and were exposed to the direct rays. We all got burnt a dark brown. Another disadvantage was that there was only just enough water to drink, so washing went by the board, and as for aseptic treatment of wounds, well that was absolutely out of the question when wounded were coming down in hundreds. Antiseptic methods were employed.

It certainly has been a great experience, and I only hope I can manage to get away to talk about it; amputations in a shed by candle-light interrupted by the passage of a shell, lying flat on one's tummy dressing men whilst bullets whistled overhead, and one had to bolt to shelter at the first opportunity. It certainly would be a good cure for those people who are too bored and blasé to take any interest in anything.

I suppose you are getting some excitement too in the way of Zeppelin raids. We have seen some of that kind of thing out here. The Turks have an aeroplane or two which they let out occasionally, but they don't seem to do very much damage. Here a man as soon as he is wounded is buzzed off as soon as possible to a hospital ship, there is nothing in the way of a base hospital on the Peninsular. At the present moment none can foresee the end of this, but I hope to be home before Xmas.

By the way, if you happen to have too many Gold Flakes lying about you might pass a few out here, one cannot get hold of a decent cigarette. Yours,

NOEL MINNS.

Obituary.

HELEN M. HERRMANN.

The death took place in London, on November 20th, of Miss Helen M. Herrmann, who was Sister of Accident, Mary, and Clinical wards successively from 1886 to 1900. She left Clinical to become the head of a Nursing Home in Weymouth Street, which post she held till 1912. Few of those who worked with her at Guy's can have forgotten her enthusiasm for her profession and the keen interest she showed towards everyone and everything that came in contact with her. She was thoroughgoing in every respect, devoted to her patients and her work, yet not narrowminded. She was a good linguist, a very appreciative critic of music and any form of art, and a traveller who had seen a great deal of three continents. Besides this, she was a staunch friend and a good woman, who will be missed by many.

British Red Cross Society,

Devonshire House, London, W.

REGULATIONS FOR V.A.D. MEMBERS (WOMEN) APPLYING FOR SPECIAL SERVICE.

Candidates for Special Service must be Members of a Voluntary Aid Detachment.

Members must send in their names through their Commandant and County Director or Secretary. In no case will individual applications be dealt with.

The Commandant will only forward the names of those Members whom she considers in every way suitable for Special Service.

In all cases the Society's Medical Certificate of Health must be filled in and signed by a Doctor. (This will be sent to all Candidates in due course.)

The Selection Board reserves to itself the right to reject any Member whom it considers unsuitable, without giving a reason.

Members, when posted, must be willing to carry out whatever duties are assigned to them. They should be willing to serve wherever required, either at home or abroad.

They must wear regulation B.R.C.S. uniform (indoor and outdoor) as detailed in Form D7, and no mufti may be taken.

All Members appointed to MILITARY HOSPITALS come directly under the War Office from date of appointment.

All Members working under the B.R.C.S. or Joint Committee come directly under the officers appointed by the Societies.

TERMS OF SERVICE.

Military Hospitals—Members in Wards.

They must be in possession of First Aid and Home Nursing Certificates.

They will be asked to be inoculated against enteric.

Those Members who have had nursing experience in a hospital will be given a preference (if their hospital report be good).

They must be between the ages of 23 and 38.

They must live in the Nurses' Quarters, and will be absolutely under the control of the Matron.

They go for one month's probation, and if considered suitable sign on for a period of six months, or duration of the War.

Salary.—£20 a year.

Allowances.—£4 a year for uniform. Quarters, food, washing, etc., paid. Travelling expenses paid.

Military Hospitals—Other Departments.

Salary.—Dispensers, £1 10s. a week; Head Clerk, £1 15s.; Clerks, £1 6s.; Head Cooks, £1 15s. (and three meals); Cooks, £1 (and three meals). (These terms do not include food (except for cooks) nor quarters.

(*a*) It will, therefore, probably be arranged that Members shall run hostels for themselves, with competent officers in charge. In this case they will be required to pay a certain sum to cover their board and lodging.

(*b*) It is not necessary for Members to be in possession of F.A. and H.N. Certificates (except in the case of Nursing Members).

(*c*) The same age limit does not apply.

(*d*) They will be appointed for one month on probation, and if satisfactory sign on for six months, or until their services are no longer required, in which case they will be given a week's notice.

Allowances.—An allowance of £2 will be made at end of month's probation, if the Member signs on for six months, and a further sum of £2 will be paid if Member signs on for further six months.

B.C.R.S. and Joint Committee Hospitals, Rest Stations, etc.

No salary or uniform allowance.

All expenses paid from London.

Auxiliary Hospitals.

Terms as arranged.

French Red Cross Hospitals.

Members pay their own expenses—10s. to 40s. a week may be asked for by the French Authorities, to cover cost.

They must speak French, and should have had hospital experience.

They must be over 23 years of age.

WEEKLY REPORT FROM DEVONSHIRE HOUSE.

October 22nd, 1915.

At Work	2,428
At Work at King George Hospital	65
Selected and Waiting	1,058
Reserve	379
Candidates (papers in process of completion)	679
Applicants for King George Hospital	14
Total	4,623
Rejected	626
Withdrawn	458
Contract Terminated	8
Total of all Candidates since October, 1914	5,715
Sent to Work during the last Week	225
Selected	194
Placed on Reserve	9
Rejected by Selection Board	51
Withdrawn	41
New Applicants	206

Acute Hæmorrhagic Pancreatitis.

The experience at Guy's Hospital during the last ten years.

EVERY now and then, on the average of a little more than once a year, a patient is admitted into the hospital suffering from an acute abdominal condition which, upon exploratory operation, proves itself to be one of acute hæmorrhagic pancreatitis. During the last ten years, from 1906—1915, twelve such cases have been admitted into this hospital, and in no single instance has an exact diagnosis been arrived at prior to operation or a post-mortem examination. This fact has suggested to me that it might be profitable to study these cases carefully with a view to discerning as to whether this condition does present a distinct recognisable clinical picture, so that the failure of diagnosis is due to the infrequency of its occurrence and lack of observation of the most salient points, or whether it so strongly resembles other states that a clinical differentiation cannot be expected.

It must be admitted that such a study is, to a great extent, merely of an academic interest, as in a large majority of cases the patient is obviously acutely ill, the site of the trouble is clearly in the abdomen, and whether we call the condition one of a perforated viscus, of general peritonitis or acute intestinal obstruction, with which it is most apt to be confused, the indication in any case is to open the abdomen and explore.

The academic interest alone would, of course, justify such a study, and, moreover, there are certain cases in which an exact diagnosis is of practical importance. In such cases the condition does not reveal itself immediately upon opening into the greater sac of peritoneum, as is usually the case, and unless the possibility of pancreatitis is borne in mind the further expediency of opening the lesser sac and exploring the pancreas is liable to be overlooked. This mistake was actually made in one of the cases in this hospital.

With regard, in the first place, to the etiology of the condition. Most of the text-books on the subject state that its incidence in the male is twice as great as in the female. These cases entirely fail to corroborate this statement; three cases were in males and nine in females, so that three-quarters were in females and only one quarter in males. And this preponderance in females is in keeping with another fact brought out by these cases, namely, the remarkable association of acute pancreatitis and gall-stones. Three-fourths of the cases of gall-stones occur in women, and if the coincidence of gall-stones and acute hæmorrhagic pancreatitis be in the relationship of cause and effect, as one cannot reasonably doubt, since they are found in so large a proportion of cases, then the preponderance in women is only what one would expect. In seven of the cases were gall-stones actually mentioned to have been found, and in another one no such mention was made, but there was a definite previous history of gall-stone colic. One of the cases was associated with a duodenal ulcer, and three had a previous history of epigastric pain and some digestive disturbance. The ages of the patients varied from 33—73, the actual ages being 33, 36, 37, 40, 45, 46, 48, 51, 54, two of 65, and one of 73. In other words, pretty much the same age at which we find gall-stones.

Some observers have drawn attention to the association of pregnancy with this condition. In these cases one woman had given birth to twins six weeks previously and another was six months pregnant. There is mention of three of the patients being addicted to alcohol, though the bearing of this factor is probably not very important. So that we see that the chief predisposing cause is the existence of gall-stones. The "modus operandi" of the stones in producing the hæmorrhagic inflammation was very well shown in one of these cases. In this case, at the post-mortem examination, a small stone was found lodged in the diverticulum of Vaten, and blocking its duodenal orifice. The common bile duct and the duct of Wersung were were thus converted into closed channels and bile could be retrojected into the pancreas. That retrojection of bile will cause a hæmorrhagic inflammation of the pancreas has been proved experimentally by injecting bile into the pancreatic duct in dogs with resulting hæmorrhagic inflammation. In another case a stone was found in the common duct.

The association of these two conditions may also be explained in another way. There is known to be a remarkable association of micro-organisms in the gall-bladder with the formation of stones; a certain amount of cholangitis always preceding cholelithiasis. This suggests that bacterial infection is an important factor in the production of pancreatitis. Alcohol may possibly set up a duodenitis which may spread to the pancreas, but such casual agents as alcohol and T.B. toxins circulating in the blood would be more likely to set up a chronic than an acute inflammation. Gall-stones may, of course, cause a temporary blocking of the duodenal orifice of the duct and a retrojection of bile and then subsequently be passed, so that they are not found in this position at the post-mortem.

Symptoms.—One of the chief points insisted upon by the text-books on this subject is the extreme suddenness of the onset; and each one of these cases corroborates this point. In each one of them the initial symptom of acute abdominal pain came on with remarkable suddenness. The acuteness of the pain is no less remarkable than the suddenness of its onset. One moment the patient is feeling well and free from pain and the next she is writhing in acute abdominal distress. Rapidly following upon this initial symptom

there is a marked degree of shock. There is a tendency for this, as for the acuteness of the pain and the suddenness of its onset, to be extreme. The shock is, as a rule, proportionately greater than in any of the diseases with which it may be confounded. In fact, death may occur within thirty-six hours of the onset as a result of the severity of the shock.

The close proximity of the solar plexus to the site of the lesion has been put forward as an explanation of this phenomenon. The nerve cells of the semilunar ganglion have, upon microscopical examination, been found to be degenerated with a leucocytic infiltration. Vomiting is an early and important symptom. Starting at the onset of the attack it is frequent, persistent and progressive. The patient at short intervals brings up small quantities of a thin bilious fluid. There is no tendency for the vomited matter to become fæcal in character, a distinguishing point from acute intestinal obstruction.

The progress of the disease from the time of onset is rapid, the patient being, as a rule, brought up to the hospital within 36 to 48 hours from the commencement. The continuity of the symptoms, together with their rapid progression is another point which aids in the differential diagnosis from other conditions, more especially from that of a perforated viscus. In a patient who is suffering from a perforated gastric ulcer, for instance, after the first onset of pain, vomiting and shock, the condition will often improve to a marked extent, so that in some cases it may even be difficult to persuade them and their friends that their condition is critical and that immediate operation is necessary; and in other cases in which so marked an improvement does not take place the pain and vomiting will often be alleviated for a time to recur later.

Such a picture as this is not seen in any of these cases of pancreatitis. In only one was there any alleviation of pain whatsoever; in all the remainder the symptoms had persistently continued and gradually increased in severity from the moment of onset. The patient is, as a rule, constipated, the constipation being due, at all events in the early stages, to a paralytic condition of the gut, resulting from shock, and not to peritonitis. Peritonitis may, of course, eventually result if the patient survive a sufficiently long time, but death, at all events in most cases, is due to shock.

Such, then, is the history and picture presented by the patient when admitted into the hospital, which is usually 36 to 48 hours from the onset, the longest period between the onset and admission in these cases being 96 hours. Upon examination the patient is seen to be acutely ill. Her face is drawn, the eyes dark and sunken; the tongue is dry and there may be constant thirst. The abdomen is, as a rule, somewhat distended as a result of paralytic distension of the gut. The range of movement of the abdomen tends to be restricted, but more in the upper than in the lower half. There is a certain amount of rigidity, though this, as a rule, is not extreme. There is never the board-like rigidity sometimes associated with general peritonitis from a perforation of a viscus or an appendicitis. This rigidity, too, is greater in the epigastric region than elsewhere.

The tenderness varies a good deal. Usually there is a certain amount all over, but more, as with the rigidity, in the epigastric region than elsewhere. Sometimes, more especially when the attack is very severe and the shock great, the tenderness is only very slight, but even then the differential distribution holds good.

A point which is brought out by many text-books in dealing with this subject is the observance of an indefinite swelling in the abdomen; such a tumour was not observed in any of these cases. That this should be so is not surprising for several reasons. Firstly, because, as already pointed out, these cases occur largely in stout women of middle age in whom it is not easy to feel anything in the abdomen at the best of times; secondly, because the site of such a swelling, presumably formed by the pancreas, is also the site of the greatest rigidity and tenderness; and thirdly, as a rule, at the post-mortem the pancreas is not found so much enlarged as would be likely to give rise to a palpable swelling. Hence this point cannot be of much value in determining a diagnosis.

Jaundice is mentioned as sometimes being present, but did not occur in any of these cases. The temperature is normal or subnormal, and the pulse generally rapid. In all but two cases it was over 110 and in one ?172. In two cases it was only 80. One of these was a comparatively mild attack and the other was a very severe one which died a few hours after operation. The explanation of the slow pulse in this latter case is obscure.

The diagnosis having been made the indication in all cases is to open the abdomen and often the diagnosis is immediately confirmed by the discovery of fat necrosis in the mesentery and omentum.

This presents the appearance of small round opaque areas of pearly white appearance scattered throughout the fat in the mesentery and omentum, and in the mesenteric glands. If the omentum be picked up these areas will often be found to be small at its lower extremity, and as the posterior two layers be traced backwards to the pancreas, to increase in size and coalesce to form areas as large as half pennies.

The discovery of fat necrosis is an almost constant feature. In only one of the 12 cases was it absent. In this case, which gave quite a typical history, a diagnosis of acute obstruction was made prior to operation. On opening into the greater sac nothing of an obstructive nature was found, and no fat necrosis to suggest pancreatitis, so that the lesser sac was not explored and a colostomy was done and a Paul's tube put in. The patient died very shortly and the true condition was revealed at the post-mortem.

The fat necrosis is, of course, due to absorption of pancreatic juice, the lipase of which acts upon the fat and saponifies it.

A second almost constant feature is the presence of a variable usually considerable amount of blood stained fluid, as a rule in the greater and lesser sacs, but occasionally confined to one or the other. The lower sac should in all cases be explored. The transverse colon having been pulled upwards, an incision is made through the post two layers of the great omentum, as in the operation of gastro-jejunostomy, a finger passed into the lesser sac and the pancreas palpated. This organ will then be felt to be enlarged and firm in consistence.

The gall-bladder and bile passages should be examined in every case. Should a stone be felt in the diverticulum of Vaten this should be dislodged, or else it will continue to cause obstruction and retrojection of bile into the pancreatic duct. The bowel is usually distended, but shiny and healthy in appearance, and there is no evidence as a rule of peritonitis. A tube should be placed through the hole in the great omentum to drain the lesser sac, and another in the pelvis to drain the general peritoneal cavity. Portions of the pancreas sometimes slough away subsequently, and are discharged through the upper tube. The percentage of mortality of this disease is very high. Three of these cases only recovered, the other nine died.

The first of those who recovered was a man aged 46, and was the mild case referred to above, in whom the pulse rate was 80, temperature 99·6, and respirations 30 at time of operation.

The second was a case of moderate severity in a woman aged 48 years, in whom the temperature was 98·0, pulse 140, and respirations 22, who made a slow recovery.

And the third was a case of moderate severity in a woman of 37 years, who also made a slow recovery after operation.

Of those that died, one recovered from the shock of the operation, but subsequently developed a B.C.C. infection of her peritoneum and died some six weeks later. The others all died within 24–48 hours of the operation from shock, except in one case, in which the patient was considered too bad to be operated upon and who died soon after admission.

The post-mortem appearances have to a large extent been already indicated. In addition to stones in the gall-bladder with signs of previous cholecystitis, in the form of adhesions of the bladder to surrounding structures, thickening of the walls, etc., stones in the duct, fat necrosis, and fluid in the abdominal cavity, it may be mentioned that the pancreas is usually found somewhat enlarged and firm and the interlobular tissue infiltrated with blood and sometimes with clots. As already mentioned, in one case a duodenal ulcer was found to be present.

Such, then, is the experience at Guy's Hospital during the last ten years of acute hæmorrhagic pancreatitis, and from it I think the conclusion may be drawn that the condition does present a distinct clinical picture and that from a careful consideration of the age, sex, previous history and symptoms of the patient and history of the attack, a diagnosis may be arrived at with a reasonable amount of accuracy.

A. L. P.

Research Scholarship in Dental Metallurgy.

In March, 1914, by the generosity of an anonymous donor, a Research Scholarship in Dental Metallurgy was established in connection with the Dental School at Guy's. The Scholarship was held from March, 1914, to May, 1915, by Mr. R. G. Parker, B.Sc., whose work has been described in two papers published in the Journal of Chemical Society for July and August, 1915, under the following titles:—

The Properties of Cold-Worked Metals.

Part I. The Density of Metallic Filings. By T. M. Lowry and R. G. Parker (Trans. Chem. Soc., 1915, vol. 107, pp. 1005–1018).

Part II. Methods of Measuring Small Changes of Density Produced by Annealing. By R. G. Parker and T. M. Lowry (Trans. Chem. Soc., 1915, vol. 107, pp. 1160–1168).

There papers are of permanent value in connection with the study of annealing, and have already been circulated widely amongst Chemists and Metallurgists through the medium of the Transactions of the Chemical Society. Additional copies of each paper are available for circulation at the discretion of the Dental Council, in order to promote the interests of the Dental School. A paper on "The Hardening of Metals" was also contributed to the Proceedings of the Dental Congress, 1914, and will be available for circulation in a similar way.

From May to October, 1915, the work was carried on by means of temporary arrangements which proved quite satisfactory; but at a recent meeting of the Dental Council, Mr. R. G. Early, B.Sc., was nominated as Dental Research Scholar from the commencement of the new session.

Mr. Early (who had already offered himself for the Army) spent the whole of the Summer Vacation in Prof. Lowry's laboratory, making materials for the preparation of novocaine for the National Health Insurance Commissioners. By the permission of the donor of the Scholarship, and with the concurrence of the Research Committee of the Dental Council, Mr. Early will now carry out, under Prof. Lowry's direction, experiments bearing on the manufacture of high explosives. It is a satisfaction to be able to state that, in connection with this scheme, information of value has already been communicated to the authorities.

Appointments.

Royal Navy Medical Service.

J. Cameron has been appointed temporary Surgeon to the *Victory*, additional, for Haslar Hospital.

Royal Army Medical Corps.

The undermentioned appointments have been made:—

Temporary Captain A. H. Carter to be temporary Major.

Honorary Lieutenants F. Morres, R. D. Attwood, B. McDermott, E. B. Smith, A. H. Spicer, C. A. R. Gatley, A. F. G. Guinness, and W. G. S. Neely to be temporary Lieutenants.

C. Witts, W. P. Ker, D. R. Pike and R. G. Chase are appointed temporary Lieutenants.

Temporary Col. F. F. Burghard has relinquished his commission.

Temporary Lieuts. W. P. H. Munden and J. L. Whatley have relinquished their commissions.

Territorial Force.

London General Hospital: Lieut. R. P. Ninnis has resigned his commission on acconnt of ill-health.

Southern General Hospital: Major J. H. L. Morrison to be Lieut.-Colonel.

Lowland Field Ambulance: A. G. Buchanan to be Captain.

Home Counties Casualty Clearing Station: W. L. Hibbert to be Lieutenant.

Herbert Elmwood, L.D.S., D D.S. Penn., has been appointed Dental Surgeon to L'Hôpital de l'Alliance Yvetot, France.

Lieut. S. H. Longhurst, R.A.M C., has been appointed to supervise the dental work in the Western Command.

Lieut. C. R. Nicholson has been appointed Special Surgeon and Registrar to Military Hospitals, Valetta, Malta, and has been given the local rank of Captain, R.A.M.C.

Roll of Honour.

The name of Lieut. H. Millett should have been included in our last issue as having been mentioned in a despatch from Sir Ian Hamilton, dated September 22nd, in connection with operations in the Dardanelles.

Change of Address.

C. J. Hinchcliff, Esq., L.D.S. Eng., from 57A to 30A, Wimpole Street, W.

Lieut. J. H. E. Winston, 3/5th Yorks Regt., St. Alma, Scarborough.

Lieut. G. T. Foster-Smith, R.A.M.C., attached 39th Div. Engineers, Witley Camp, Milford Surrey.

Capt. T. S. Keith, R.A.M.C., No. 3 Field Ambulance, Nasorieh, I.E.F.D.

Capt. C. de W. Gibb, R.A.M.C., 15th Field Ambulance, 5th Div. B.E.F.

Second Lieut. C. D. Bishop, 28th Battalion Middlesex Regiment.

Lieut. P. J. Monaghan, R.A.M.C., 1st Field Ambulance, South African Overseas E.F., c/o G.P.O.

Lieut. E. F. Reeve, R.A.M.C., from Rainhill Asylum, Lancashire, to 30, General Hospital, B,M.E.F.

Second Lieut. G. H. Stone, London Rifle Brigade, Sutton, Surrey.

E. P. Deverall, Esq., L.D.S., Uplands, London Road, Luton, Beds.

Lieut. S. H. Longhurst, L.D.S., R.A.M.C., The Westminster Hotel, Chester.

Lieut. A. J. Gwatkin, R.A.M.C., No. 4, Stationary Hospital, B.E F.

Lieut. P. C. Litchfield, R.A.M.C., 15, Motor Ambulance Convoy, 3rd Army, B.E.F.

Capt. C. R. Nicholson, R.A.M.C., from Serbia, to the Military Hospital; Valetta, Malta.

Capt. A. Tilbury, R.A.M.C., from the Barracks, Canterbury, to Med. Exp. Force, Boulac Palace Hospital, Cairo.

Pass List.

University of London.

THIRD (M.B., B.S.) EXAMINATION.

At the Examination held recently the following candidates were successful—Frederick Alexander Beattie, Cyril Henry Edwards.

At the same Examination David Sydney Graves passed in Group I.; and Claude Wells Wooloton Baxter in Group II.

Royal Colleges of Physicians of London and Surgeons of England.

At a meeting of the Comitia of the Royal College of Physicians of London on October 28th, and of the Council of the Royal College of the Surgeons of England, on November 11th, the Diplomas of L.R.C.P. and M.R.C.S., were respectively conferred on the following candidates:—Thomas Hugh Edey, Henry Hawes Elliott, Alexander FitzGerald Grattan Guinness, James Phillips Jones, Eldon Munro Litchfield, Wilfred Guy Stuart Neely, L.D.S. Eng., William Douglas Newland, Aubrey Dear Vernon-Taylor, L.S.A.

Royal College of Surgeons of England.

FINAL L.D.S. EXAMINATION.

At the recent Examination the following candidates were successful:—G. Dee, E. P. Deverall, C. R. Martin, P. R. C. Martin, J. L. Mugford, G. M. Thomas, H. L. Thorn, R. G. Wilshere, M. G. Henry.

Births.

BRANGWIN.—On the 17th November, at Swatow, China, the wife of C. H. Brangwin, of a daughter.

CRESSWELL.—On November 15th, at 24. Windsor Place, Cardiff, the wife of F. P. S. Cresswell, F.R.C.S., of a son.

Marriages.

HUNT—STRAUSS.—On November 20th, at Christ Church, Lancaster Gate, London, W., Captain George Herbert Hunt, R.A.M.C.(T.), to Rosie Evelyn, daughter of the late A. H. Strauss and of Mrs. Strauss of Lancaster Gate, London.

WATTS—WEBB.—On November 13th, at St. Giles', Camberwell, Captain Hugh Watts, M,D., I.M.S., to Dorothea Ann, younger daughter of Mr. and Mrs. Webb of "Dulcote," Lordship Lane, London, S.E.

DONNELL—SKINNER.—On November 11th, at the Parish Church, Burton Hastings, Warwickshire, Joseph Hollins Donnell, Captain R.A.M.C.(T.), to Ada Marian, younger daughter of James Skinner, of "Lucknow," Maidenhead.

F. A. K.

GUY'S HOSPITAL GAZETTE.

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Passim.

ONCE again Christmas is with us, and if it finds us sadder than in other years, our sadness will add infinite sincerity to our feelings as we raise a glass to the toast of "Absent Friends."

Would that they could be with us; would that just for a few brief hours the clouds could be driven afar and the old-time spirit knit us together in our festivities! For a while we at home will doubtless find all care dispelled in our efforts to carry the troubled mind of many a patient from its introspective misery, but before yielding to this temporary oblivion we give our most heartfelt wishes for the welfare, safety and joy of our friends and readers the world over.

As these notes go to press a year is fading in which so many lives around us have been wrenched from their accustomed furrows; developed beyond our wildest dreams, broken beyond our most sanguine hopes of repair or too often on earth for ever lost; that we who remain, outwardly immune to the time's overpowering influence, inwardly claiming to uphold a spirit of patriotism and unity justly comparable with that of many more vaunted institutions, can well afford to indulge in some analysis of ourselves and our achievements.

Politically, our duty is being surely—though but gradually—defined, and perforce such definitions, when provided, must we take for our guidance,

"But tasks in hours of insight will'd,
Can be through the hours of gloom fulfill'd."

So in the crisis of to-day one common possession—conscience—provides a universal power of decision. There can be no doubting, for the path is shown to all. The firmness and energy of our steps are our sole responsibility, and we hold that the fields through which we pass are momentarily of little consequence provided that the great cause of humanity is aided with our maximum endeavours.

We applaud and appreciate our Staff's attempts to hasten and assist in the production of this official guidance and most decidedly disagree with the suggestions made by certain colleagues and contemporaries that these overtures were uncalled for—or at least premature. The economy of to-day demands official definition for all and everything, but pending its appearance we are proud in the belief that every man with us is giving of his best, and that when old Guy's shall need him no longer he will not hesitate to serve the land that bore him—even up to the Greatest Sacrifice.

WE offer our congratulations to Sir Cooper Perry on his election to the Senate of the University of London.

The proposed excursions of the Niggers to Government hospitals at Hampstead and Southend come this year as an innovation. We wish the troupe all success in its good endeavours.

We have to thank many friends and contemporaries for their expressions of goodwill and remembrance, and reciprocate their feelings in the fullest degree.

We had intended publishing two photographs this week of the late Dr. Assheton and Lieut. Hogben, but owing to unavoidable circumstances, they will not appear until our next issue.

Obituary.

RICHARD ASSHETON.

Another gap has been made in the ranks of English biologists, and again it relates to a former teacher at Guy's. A short time ago was published in the Gazette an obituary notice of Professor Minchin, and now it is our sad duty to give an appreciation of Dr. Assheton, who was well known to many of the past and present students of Guy's.

Dr. Assheton's connection with our Medical School began in October, 1901, when he was appointed Lecturer in Biology, a post which he held until January, 1914, when he resigned to take up his duties as Lecturer in Animal Embryology at Cambridge. He came to Guy's with a reputation for both research and teaching; at Cambridge, after taking his degree with a first class in the Natural Science Tripos in 1886, he worked at embryology under Balfour and Sedgwick. His experience as a teacher had been obtained in the Victoria University of Manchester, where he held from 1889 to 1893 the post of Lecturer in Zoology under Professor Milnes Marshall.

Although the appointment he held at Guy's was a part time one and he lived at Grantchester near Cambridge, Dr. Assheton took a keen interest in the welfare of the Medical School and the London University. His views upon education were sound and he taught his subject from the true standpoint of a University, not from the lower level of a technical school. As in other universities, there were in London members of the Medical Faculty who wished to limit the teaching of Biology to those parts directly applicable to the work of the medical student. These views and the attempts made to give effect to them Dr. Assheton controlled in his characteristic manner, a calm and dignified protest underlying which could be discerned a sense more of painful surprise than contempt for a narrow outlook. His truly scientific attitude was reflected in his ordinary teaching and especially in the course of advanced lectures which he gave under the auspices of the Board of Human Anatomy and Morphology.

Dr. Assheton was an excellent lecturer and teacher, and was deeply respected by his pupils and colleagues. He had a striking personality, a reserved and dignified bearing, and took a keen interest in research work outside his own subject. When his aid was sought, he gave most willing help and guidance. Owing to the peculiar conditions of part time appointments in the Medical Schools of the University, Dr. Assheton did not receive the full academic status which the workers in his own subject recognized as rightly due to him. There is no doubt that the ambiguity of the situation thus produced worried him, but full compensation came when he was elected a Fellow of the Royal Society, and was appointed Lecturer in Animal Embryology in his old University in 1914. In addition to teaching and research he was engaged in writing a text-book of the embryology of the mammalia; his devoted services, however, were cut short by his death on October 24th, 1915. The following list of publications will show the extent of his contributions to knowledge; reprints of these papers will be bound together and deposited in the Wills Library.

G. W. N.
M. S. P.

List of Publications.

On the development of the optic nerve of vertebrates and the choroidal fissure of embryonic life, *Quar. Journ. Micro-Science,* vol. 34, August, 1892.

A re-investigation into the early stages of the development of the rabbit, *ibid.*, vol. 37, Dec., 1894.

On the phenomenon of the fusion of the epiblastic layers in the rabbit and in the frog, *ibid.*

On the causes which lead to the attachment of the mammalian embryo to the wall of the uterus, *ibid.*

The primitive streak of the rabbit, the causes which may determine its shape, and the part of the embryo formed by its activity, *ibid.*

On the growth in length of the frog embryo, *ibid.*

Notes on the liliation of the amphibian embryo, *ibid.*, vol. 38, Feb., 1896.

An experimental examination into the growth of the blastoderm of the chick, Proc. Royal Society, vol. 60, 1896.

An account of a blastodermic vesicle of the sheep of the seventh day with twin germinal areas, *Journ. of Anat. and Phys.*, April, 1898.

The development of the pig during the first ten days, *Q.J.M.S.*, vol. 41, Nov., 1898.

The segmentation of the ovum of the sheep, with observations on the hypothesis of a hypoblastic origin for the trophoblast, *ibid.*

On growth centres in vertebrate embryos, *Anat. Anzeiger,* vol. 27, 1905.

The morphology of the ungulate placenta, particularly of that organ in the sheep, and notes upon the placenta of the elephant and hyrax, Proc. Royal Society, vol. 76, 1905.

On the fœtus and placenta of the spiny-mouse, acornys lahirinus, *ibid.*

Certain features characteristic of teleostean development, Guy's Hosp. Rep., vol. 61, 1907.

The development of gymnarchus niloticus.

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Fission of the embryonal area in mammals, *Zool. Congress Monaco,* 1913.

With Dr. A. Robinson—Formation and fate of the primitive streak, *Q.J.M.S.*, vol. 32, 1891.

With Dr. T. G. Stevens—The elephant's placenta, *ibid.*, vol. 49, 1905.

Nephelococcygia.

"In Ausonian land
Men called him Mulciber, and how he fell
From Heaven they fabled, thrown by angry Jove
Sheer o'er the crystal battlements; from morn
To noon he fell, from noon to dewy eve
A summer's day, and with the setting sun
Dropt from the zenith, like a falling star
On———"

Here I must stop. I know that the Censors are simply death on poetical quotations, and if I completed these majestic stanzas I might get blotted out entirely, as the indication of the place where Mulciber, or Vulcan, did drop might be considered news likely to afford valuable information to the enemy; and though I think that I have bought the only copy of the poet's works in Alexandria, the Censor may be so versed in English literature that he can from memory supply the missing words. If so he must decide the fate of this letter; but should it arrive safely in St. Thomas's Street, I leave it to the Editor to complete the quotation. If he cannot, let him repair to the Superintendent, who, I am sure, will enlighten him.

Now where Vulcan dropped previously, some years before the war, he has certainly dropped again. A natural harbour, as large, if not larger, than Richmond Park, is alive with the product of a thousand forges; battleships, cruisers, submarines, destroyers, supply ships, transports and hospital ships are here riding at anchor, and among these giants a crowd of small craft, launches, motor lighters, "sardine boats," and "beetle boats," puffing and rattling to and fro.

All around the harbour are low yellow hills. They say that in the springtime they are green and covered with flowers, but now they are bare, stoney and dusty, only covered with dead thistles, a dreary wilderness. These slopes and hills are covered with tents, the whole twelve miles circumference of the harbour being speckled with them like little crops of mushrooms. Not only are there hospitals for about ten thousand cases, all under canvass, but there are also convalescent camps and rest camps for troops, so that all day long there are continual movements of ambulance wagons, troops marching in and marching out, bands, and bugle calls from all the distant hills.

The wind blows nearly always, hard from the north for three or four days, then suddenly veering round to the south for an equal period, then east or west and so back again (was not the cave of Aeolus and the winds on ——?). And in whatever quarter the wind may be you can never escape the characteristic odour of the place, the smell of the smoke from the incinerators; for with Vulcan there came also to the island this time Beelzebub, the Prince of Flies, and his legions, and to escape this plague every scrap of waste, offal or rubbish must be burnt. So imagine yourself living in a suburban garden with your neighbours perpetually burning rubbish (only the rubbish here is much more noisome than dead leaves), and you may conjure up a faint idea of the spicy breezes of the island.

Inland the hills rise to about fifteen hundred feet, and in the valleys there are pretty clean Greek villages with fig trees and vineyards; and heavy handsome peasants, still true to the old Grecian type, wearing the sheepskin coat, baggy trousers, gaiters and turban that one associates with Byron and the Greek revival of an hundred years ago.

At the top of the highest peak there is a small votive Greek chapel with byzantine icons on the altar; the whitewashed walls now, alas, absolutely covered with the names of pilgrims from Wanganui, Woolloomoolloo, and other centres of civilization in the southern hemisphere.

From the peak one can look over the island to the little port on its western side; eastwards is the Asiatic shore, Tenedos, and the Beaches; northwards, towering above the other islands, Samothrace, its mountains often tipped with snow. Of clouds and cuckoos only the former may be seen, streaming down the sunny wind, but red legged partridges there are, fairly common in the rolling inland hills. In romance, "the primrose path of dalliance" are there not the Canadian nurses, fairer and smarter than any others, unpatriotic as it may be for me, an Englishman, to say so. Happy is the sick or wounded subaltern who gets into the wards of a Canadian hospital, and numerous are his visitors!

Somehow, nevertheless romance seems out of place in ——. The things that linger in one's memory are stones, dead thistles, flies, and the smell of the incinerators, and if the censor has been there he will have no difficulty in picking up the clues I have given him. E.

Three Cases of Typhoid Fever with Uncommon Complications.

THE following cases occurred among Belgian civilians and refugees in Flanders. The comparative rarity of the complications in each instance seemed sufficient to warrant the publication of the notes relating to them.

1. *Hæmorrhage into Rectus Muscle, with symptoms suggesting the presence of Peritonitis.*

C. G., male, æt. 55, was admitted on the fourth day of disease with headache, pyrexia, malaise, brown furred tongue, and muscular tremors. His wife and daughter were in hospital with typhoid fever. The spleen was not palpable, and there were no roseolar spots. Bacillus typhosus was obtained in pure culture from the blood. On the ninth day of disease patient was given a small dose of living vaccine prepared from his own culture. On the following day there was a brisk local reaction, but no apparent change in the temperature or general condition. On the eleventh day of disease, in the morning, patient complained of severe pain in the left lower quadrant of the abdomen; his general condition was worse, the facies appearing more sunken and his weakness more pronounced; the pulse-rate was 120. On examination the abdomen was found to be rigid and very tender over the left rectus; elsewhere there was no rigidity and movement was not markedly impaired. At the same time the respirations were observed to be increased in rate and there were crepitations at both bases; the patient also complained of earache. The leucocyte count at mid-day was 6,250 per cubic mm. Patient became steadily worse during the day, but the pulse-rate remained between 104 and 116. At six o'clock in the evening the abdominal signs were no more generalised, but there was a perceptible fulness in the area of pain and rigidity. Rectal examination revealed no pelvic pain or swelling, and the leucocyte count was still 6,250. The short duration of the illness, the continued localisation of symptoms, and the low white-count were considered to oppose a diagnosis of perforative peritonitis, and the condition was thought to be one of localised peritonitis due possibly to inflammation over the ulcerated coil of intestine. A binder was applied to the abdomen, and morphia, one-sixth of a grain, given hypodermically. A swab taken from the fauces, which were inflamed, gave a growth of Klebs Leoffler's bacillus.

The respiratory symptoms became aggravated, and there was some blood-stained expectoration; signs of heart-failure supervened, and the patient died on the twelfth day from the onset of the disease.

Post-mortem Examination.—The first incision revealed the cause of the abdominal symptoms which had given rise to anxiety during life by suggesting the possibiilty of acute peritonitis. There was an extensive hæmorrhage, without apparent rupture, into the left *rectus abdominis* muscle, and a slight hæmorrhage into the muscle on the right side escaping from the sheath, the effusion tracked laterally in both directions behind the peritoneum and could even be traced between the layers of the meso-cæcum. Other findings included acute bronchitis, œdema, and hypostasis of the lungs and emphysema, fatty degeneration of the heart, an enlarged spleen and recent ulceration of the ileum.

Conclusions.—(i.) Abdominal pain, tenderness, and rigidity, with a rising pulse and a rapid deterioration in the general condition and facial aspect, appearing in the course of an attack of typhoid fever, need not signify an acute intraperitoneal condition. (ii.) The leucocyte count is a valuable aid in differentiation.

2. *Purulent Peritonitis without Perforation. Pyæmia.*

S. B., female, æt. 39, after an illness without an available history, developed an empyema on the right side. An operation was performed and the cavity drained. The patient, however, became worse and died. At the post-mortem examination, in addition to the empyema cavity, were discovered (1) a left-sided pleural effusion (fluid opaque); (2) Pericarditis with effusion; (3) Purulent fluid (two to three ounces) in the left flank, bounded by coils of intestine; (4) Soft enlargement of the spleen with small yellow infarct in lower pole and perisplenitis; (5) Thrombosis of left internal and external iliac veins and inferior vena cava; (6) Absence of ulcers in the lower ileum.

Bacillus typhosus was recovered from the liver, the bile, and the purulent fluid in the peritoneum; streptococci were found in the pericardial fluid. It was suggested that the pus in the abdomen might have resulted from the rupture of a mesenteric gland infected in the acute stage of typhoid fever, and that the thrombosis and general pyæmia were secondary to this peritoneal infection.

Osler mentions crural thrombosis and the suppuration of mesenteric glands as rare causes of pyæmic infection in typhoid fever.

3. *Laryngitis necessitating Tracheotomy. Recovery.*

J. V., male, æt. 18, was one of a family of eight cases of very severe typhoid fever originating from the same house. He was admitted on the eighth day of disease with delirium and incontinence. The spleen was palpable, there was a roseolar rash, and bronchitis with slight cyanosis was present; the pulse was dicrotic. Bacillus typhosus was cultivated from the blood. The patient was treated with small but increasing doses of stock army vaccine, with only doubtful benefit.

About the fourth week of disease a laryngitis developed, a hard cough and aphonia being the main symptoms; incidentally the patient's brother simultaneously developed a similar laryngitis. No K.L.B. were isolated from a swab taken from the fauces, and there was no membranous exudate. Bacillus typhosus could not be grown from the sputum. After a few days the laryngitis became obstructive. Tracheotomy became necessary and was performed by Colonel Guise Moores, A.M.S. After three days the tube was left out altogether; the wound healed well and the patient made an uneventful recovery; a swab taken from the trachea grew pneumococcus. It is possible that the laryngeal ulceration, occasionally proceeding to necrosis of a cartilage, that is described in association with typhoid fever, may have been present in this case, but it was not demonstrated. The symptoms and course rather suggested œdema or spasm as the actual cause of the obstruction. Ker in his Infectious Diseases states that "not more than half a dozen of my patients suffered from obvious laryngitis, and in only two did necrosis of a cartilage follow. Both the latter succumbed, one after tracheotomy. In a few others slight ulcerations, unsuspected during life, were observed in the post-mortem room." *According to Osler, laryngitis is not a very* rare complication of typhoid fever.

Thanks are due to Captains Stokes and Clarke of the R.A.M.C, by whom the bulk of the pathological work on these cases was performed.

J. A. RYLE,
Capt., R.A.M.C., S.R.

Letters from Guy's Men on Active Service.

Howe Batt'n,
Royal Naval Division,
B.M.E.F.,
Nov, 7th, 1915.

Dear Sir,

I thought you might like some news of one or two Guy's men out here in Gallipoli. Schlesinger is often to be seen about sometimes on a horse, or "would be" horse; booted and spurred—his fearsome mount looking as if, in its better days, it had supplied the motive power to a lawn mower. At other times he flashes by on a motor bike, without a silencer, making a noise like 20 Taubes in full flight. He is *the* surgeon of the 1st Field Ambulance of the Naval Division. He has done great work there from all accounts. Previous to that he was M.O. to this battalion, and made a great name for himself and Guy's, by his bravery and devotion to duty under fire, being mentioned in dispatches on, I believe, two occasions.

Fry came out here, and was in the 1st F.A. also, but he did not survive more than about a month, being one of the many victims of dysentery. By now I expect he is back in England again.

Creasy, complete in a flowing black beard, and with a dazzling red waistcoat, is often to be seen at the 3rd Field Ambulance of the Naval Division, as is also Crook, who often performs with great credit in the local soccer matches, often played under shell-fire from Achi Baba!

November out here is a splendid month, blue skies, a warm sun, just not too hot, combined with sea-bathing, tend to make it quite a decent place.

When I was in Alexandria in August, I ran across Venables; also Parry, who was calling there in a hospital ship.

So far, since I came out, I have been M.O. to this Battalion, a most enjoyable job in every way. We do one spell up in the trenches, then get down to rest-camp for a while. Never being for long in one place prevents the life becoming monotonous. With the end of summer, sickness has gone down tremendously; at one time one used to have to send from 10 to 20 away daily with dysentery, then jaundice broke out, and was also very troublesome. In this present trench, warfare casualties are not very numerous. The North Sea is certainly far more comfortable than this, you at least can get more or less of a wash at times, and a certain variety of food. Out here we wash in biscuit tins, when we wash at all, and as to food; butter, and any vegetables are almost unheard of luxuries. Beer is seen at rare intervals, brought over by someone who has been on a few days leave in a neighbouring island, and has had to pay eighteenpence for a bottle of it! It's poor stuff even then. *Even in rest-camp we live in small* "dug-outs," as we are still under shell-fire from the Turks, when they have any to spare. The "phiz bang" high velocity shells from Asia are really far more alarming than those from behind their trenches on the Peninsular. We have often thanked our stars that *we* are the naval power and not the Turks, it is fine to see some of our 10 or 12 in. naval shells being landed straight into their trenches from our ships. They never shell us with anything larger than 6 in., and that's bad enough. However, when the Germans arrive in this part of the world, then we shall probably see *some* shells. Still we can wait for that. This is a weird sort of division—soldiers in reality, but with ratings of A.B., Petty Officer, etc., and a sprinkling of genuine "pucker" naval men, but they are now becoming treasures few and far between.

When passing through Malta in August, I had dinner with Col. Charters Symonds, who is out there, on the Army Medical Staff. He looks years younger now, with his beard shaved off, and wearing a red banded staff cap, with gold peak.

I expect most of this letter is quite unreadable—writing on a biscuit tin with a sand bag to sit on, and only an old pencil and scraps of paper is not exactly the easiest way to write letters.

You might tell Philip Scott to write to me sometimes; is Tanner still about? if so give him my chin chin. Yours,

H. PARRY PRICE, Surgeon R.N.

Alexandrea ad Ægyptum.

A LONG yellow town, on a long yellow spit of sand, facing north to the blue tideless Mediterranean; high overhead the blue vault of the sky, higher than we ever see it in England, flecked by a few lazy cumulus clouds; down below in the narrow streets, bordered by tumble-down brick and plaster houses, a crowd of Egyptians, Arabs, Greeks, and Italians, Arab horses and Egyptian donkeys, carts, hand barrows full of dates, and taxicabs, all pushing and driving anywhere; and everywhere soldiers, ambulances, army nurses and V.A.D. girls. Such is the Alexandria of to-day, the real base of that desperate adventure, the Mediterranean Expeditionary Force. Nevertheless, the peninsular and the war seem very far away, for the newspapers serve up the most meagre information, and there are no Zeppelin raids or the Stygian darkness of the London streets to infuriate or depress one.

The eastern harbour, the Portus Magnus of the Greeks and Romans, is empty now, save for a few fishing boats with their triangular sails; but in the western harbour, the ancient Portus Eunostos, the "harbour of safe return" (and may that name be of good omen for many a brave man leaving it to-day), is full of shipping. Transports, colliers, tramp steamers, and liners lie side by side in long lines, and, most impressive of all, the great hospital ships with white hulls and the long green bands.

In the daytime there is little movement, but just before sunset, or in the early morning soon after sunrise, these "shuttles in an empire's loom" glide out towards the west and either continue in that direction of Malta and home, or turn north to Mudros and the Beaches.

Surely, if stories of "revenants" are true, and the shades of the great departed do return to earth and visit the scenes of their former triumphs, there must be some august visitors here. Alexander the Great, that illustrious Macedonian, who founded the city, Julius Cæsar, Anthony and Cleopatra, the Ptolemies, Cyril the Deacon and Hypatia, Athanasius—what do they think of this, the greatest expedition that the world has ever seen? Every famous spot is full of the panoply of war. At Mustapha Pacha, the site of the camp of the old Roman army of occupation, there is a great convalescent hospital; at Chatty and the "Camp de César" is another huge encampment, and the British horse lines are on the site of the Necropolis of the Ptolemies; while Australian soldiers bathe every morning on the beach at the spot where legend has it that St. Mark achieved martyrdom.

In this old, old spot of the old world the newest of the new worlds is very much in evidence. The Australians and New Zealanders are everywhere, far more numerous than the English or the French, and if you really want to realise how they fit into the picture you must take down Charles Kingsley's "Hypatia," and read his description of the Goths in Alexandria. There they are to the life, men of magnificent appearance, the finest fighters that this war has seen, but to those of a more concentrated urban civilisation, great turbulent children. Spending their money freely, they pervade the streets, they crowd the music halls, they swagger about spoiling for a fight and often getting one. To salute an officer is a habit almost unknown to them, and of discipline in the ordinary parade ground sense they are to a great extent contemptuous; but fight!—they are the admiration of the world and the terror of the enemy, and they alone of all the wounded who return from that hell upon earth in Gallipoli seem anxious, even insistent, to get back to the trenches and have another round with the Turks. Well may Australia be proud, and Alexandria a little frightened, of them.

This new crisis of the war, brought on by the treachery of that Coburg Mephistopheles who sits on the throne in Sofia, makes the atmosphere rather tense in Egypt; but luckily the palimpsest of history that is written everywhere in this country leads one to long views. And after seeing in Cairo the mummy of that Great Rameses, the Pharaoh of the Exodus, lying dead, embalmed and harmless these three thousand years, one cannot help consoling one's self with the reflection that a day also is relentless coming when William, Francis Joseph, and Ferdinand will all in their turn meet their Maker and their doom, and that other attempts at world dominion have broken greater men than they.

E.

Scurvy.

RECENTLY I have seen two cases of scurvy in children. In a varied experience of over twenty years' practice these are the first that I can recall. They both occurred in children of eight or nine months old. The text-books declare the disease to be very rare—almost unknown—amongst the better classes. Both my cases occurred in well-to-do houses, with very careful mothers.

The first was a fat infant, rather pale, that obviously had very tender legs, so that every movement caused it pain, especially at night. Its gums were blue and swollen over the incisors that were being erupted. There were curious patches on the legs the size of a shilling that looked like erythema rheumatica. The temperature was normal. Thinking the case an unusual form of rheumatism, I prescribed Sodii Salicylites with some improvement. Another doctor declared the disease to be scurvy, and cured it in less than a fortnight with orange and grape juice. This child had been fed on milk and Allenbury's food.

The second child has had pain and tenderness of the legs for a week; a blue swelling of the gums about the erupting incisors: two small extrusions of blood under

the lower eyelid, just like mild "black eye." This one had for the past three months been fed on Benger's food, with about 25 ounces of milk in the 24 hours. He had also had two teaspoonfuls of orange juice every other day. Bowels have been normal. One week of cooked apple, orange juice and grape juice, omitting the Benger's food and giving milk and bread crumbs and gravy, have practically cured him. There are reports of other cases of the same kind in this district. It will be noted that in neither of these cases had milk been withheld. Babies that have not their mother's milk clearly require fruit juices in fair quantity. *Experientia docet.* It would be very interesting to learn if other doctors have had a like experience.

VAUGHAN PENDRED, M.D., F.R.C.S.

A Take-in Case.

Yus, doctor, i 'ad 'ad trouble with me stummick for a long time, and no wonder wiv my pore little Chawley, 'im wot goes to school with 'Erb Watkins, 'aving consumption of the bowels, and 'is sister wiv it in the knee pan—orl right, young man, I am a telling yer of me own troubles, ain.t I. Well, as I was a saying to Mrs. O'Connell, 'er wot keeps the little shop darn Deptford way, only the other day, and she's 'ad some trouble wiv all her boys in the Army—orl right doctor, I will keep to the point as yer say.

Well, I've 'ad pain in my stummick fer monfs, and last Choosday I was took sudden wiv excrusheating pain if you'll pardon the expression doctor. so I thinks I'm a norspital case, so I goes to me panel doctor and 'e says, 'e wouldn't touch me, 'e says, you go to Guy's ma'am, they are good there, if fussy.

So I comes up in a nambulance late at night, it being free in the morning, and I comes in the Out patient department, and there the doctors all come round and prod me stummick. They says, "Orl right, mother, we won't hurt you," and then they shoves them great fingers in me stummick.

Well, I gets taken up to the ward here, and they does it orl over again. They calls up one doctor, wot lives close by, and he prods me. Then another doctor, 'im wot's rather bald, 'e prods me.

Then another one, a great clumsy chap, wot upset most things, 'e prods me, Then they sort of winks at one another, and before I knew where I was another doctor wiv a white coat was sayin, "Blow it away, mother."

Then the only thing I remember is more bumpin abart on wot they calls a trolley, but what I calls a corfin on wheels, only it makes a jolly sight more row, and I was back in bed agin wiv bandages orl round me stummick.

Well, I will say I am comfortable in this 'ere ward. The nurses they can't do enough for yer, and the Sister she's a lady.

The 'ead doctor, too, 'im wot's a lord, or knight, or what not, 'e's a gent, 'e is. 'E takes as much trouble seeing we're comfortable as if we was some of these 'ere ladies we sees learning to nurse in a fortnight.

Thanky doctor, Hi'm orlright, honly I do wish yer'll let me get a word in edgewise.

Guy's Hospital Missionary Society.

RECEIPTS.

1915.		£	s.	d.
Jan. 1.	To Balance brought forward :—			
	Cash in Bank ... £5 13 7			
	Petty Cash in hand 0 8 2½			
		6	1	9½
Nov. 30.	Subscriptions, etc.	15	0	0
		£21	1	9½

PAYMENTS.

1915.		£	s.	d.
Nov. 30.	By Subscriptions to other funds £3 4 4			
	Printing, Stationery, Magazines 2 1 11			
	Postage, etc.... ... 0 7 5½			
		5	13	8½
	Balance carried forward :—			
	Cash in Bank ... 13 16 7			
	Petty Cash in hand ... 1 11 6			
		15	8	1
		£21	1	9½

Audited and found correct by

W. J. CURRY,
Corporate Accountant.

Change of Address.

Capt. R. Tilbury, from the Barracks, Canterbury, to M. E. F. Boulac Palace Hospital, Cairo, Egypt.

G. H. Aylen, L.D.S. Eng., Rothsay, from 54, Victoria Road South, to 16, Victoria Road South, Southsea.

A. F. Salsbury, L.D.S., from 29, Haldon Road, to Birchwood, Sydney Road, Guildford, Surrey.

2nd Lieut. W. R. Ransford, I.A.R.D., 10th Goorkha Rifles, from Takdal Cant, Darjeeling District, to Lansdowne, United Provinces, India.

Lieut. C. H Edwards, Stamford Road War Hospital, Norbury, London, S.E.

Capt. Cyril Sherris, R.A.M.C., No. 6 General Hospital, Rouen, France.

"War Surgery."

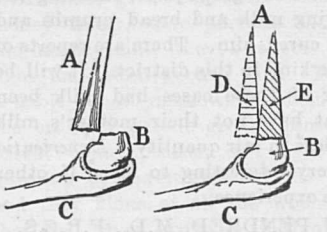
ABSTRACT OF CLINICAL LECTURE BY SIR W. ARBUTHNOT LANE.

THE nature of the injuries received in this war has caused revision of some of the previously much employed practices.

Injury to nerves has been treated by the method of suturing, but unfortunately so great have been many of the smashes, and so complicated the side issues, that very bad results have attended the operation, frequently resulting in failure to regenerate and consequent complete or partial loss of functions in the limb. The "leave it alone" principle, however, has had very promising results. The principle arose from a chance case in which the patient suffered from complete loss of movement and sensation on the distribution of the ulnar nerve as the result of a blow on the elbow. On exposure, the nerve was found to have a marked swelling developed on it, and the peripheral part was thin and degenerated; the swelling was cut along its long axis several times, and the wound sewn up; very soon afterwards sensation and movement returned along the ulnar distribution, far too soon for any physiological regeneration—in fact, the case was inexplicable at all on physiological lines. Thus, with the experience of this case as a foundation, injuries to nerves were left severely alone, on the chance that they would recover without interference, and then, if no recovery occurred, treatment by shreading gave good results. In these war injuries markedly bad results occur when suturing is attempted, so they should be left alone, and if, after nine months or so, there is no attempt at recovery of movement and sensation, the nerve should be bared and the injured parts shreaded longitudinally.

Turning to the injuries of bone, the same things seem to apply: much damage has been done by too early interference.

Bone, when injured, is capable of very far-reaching efforts in the direction of repair. Take the case of the child whose lower humeral epiphysis has separated and is lying posterior to its proper position. The direction of the forces along the humerus are now somewhat behind the shaft on to B; as a response, nature causes a "crystallisation along lines of force," so that new bone is laid down in the shaded area E, but at the same time the useless wedge of bone D is removed; thus the shaft rejoins the epiphysis. The teaching of this "crystallisation along lines of force" led to the plating of bones, so that the two ends were in some degree in apposition, and thus the intervening intervals would fill up, compact bone being laid down along the lines of force.



Now plating is all very well if done at the right time and in the right way. It has been the practice at the front to put little short two-hole plates on to the ends of broken bones almost as soon as they come in. The results, as far as the people at the front were concerned, were excellent, for the patient was no longer subject to the pain of loose fragments grinding together, and all seemed to go well. Now the patient is sent to England, and he begins to discharge pus in ever-increasing amounts, and all we can do is to sit by and wait for the plate, plus the bone to which it is attached, to separate off and come away. We cannot aid matters much, for there is no means of judging how much of the bone is really dead. The results are, therefore, really bad, and it is only because the surgeons who do the plating are not able to follow the case far enough that the method has received its praise.

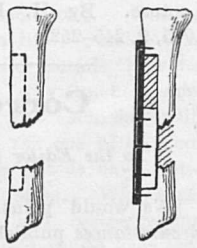
If, however, the principle of "leave it alone" is applied, then the results in the end are excellent; the bones unite in any sort of position with the intervention of much callus, and the tissues become healthy. Now the bone is laid bare, and by means of a large chisel the callus is chipped away and the bone broken at the original sites of fracture; the pieces are dragged into their proper position

and fixed there by long plates, which range from eight to eighteen holes; the screws are placed so that they do not impinge on the immediate neighbourhood of the fracture. Take the case of a man who fell from an aeroplane in Egypt; his femur was crumpled up, but after a long period the pieces were broken up again and pieced together, and now he has a useful limb which is but half an inch shorter than the other.

The success was aided by an attempt to reproduce the conditions which aided the child's bone to lay down new bone along the lines of force—that is, a condition of great vascularity. This was brought about by getting the patient up on an ambulatory splint, wherein the weight was transmitted to the tuber ischium, and yet the limb in a pendant position was flooded, as it were, with blood, and therefore nutrient material.

Again, two other cases of officers returned as useless prisoners from Germany, each with one femur four and a half to five inches shorter than the other. These were treated in the same way, and one is already back in the Army and the other nearly ready.

Suppose that a part of the shaft is missing, or has been excised or necrosed; then to get the limb back to normal length the interval must be filled up, and this is done by using a part of the bone from the same limb, thus ——➤



The intervals may or may not be plugged up with pieces of sound bone, but in any case they will fill up eventually on the crystallisation principle.

Now nature seems to store up a reserve of material somewhere in the event of an injury to bone, and when this store is sufficient, it is liberated and laid down round the site of the injury and forms the callus. This is no doubt beneficial in cases where the best has to be made of a bad case, but it is strange that in cases where there is no call for all this use of material, nature is peculiarly improvident and piles it on nevertheless. As a consequence, if a bone is to be plated, circumstances permitting, it must be done at once, before nature begins to lay up its store; otherwise, in spite of the correct apposition of the bones, masses of callus will be piled up all round and cause serious inconvenience. If circumstances prevent immediate plating, then the callus formation must be allowed to subside before the attempt is made.

Again, a fracture in the neighbourhood of a joint seems to demand absolute rest, for if massage be begun almost at once, then a beautifully free joint is soon obtained, but which thereafter may become increasingly limited and eventually quite immobile, due to growth of callus, causing mechanical interference, and thereby bringing about the stillness which nature requires, but which also necessitates surgical aid to free the joint subsequently. So once more, "leave it alone," and deal with the stiff joint afterwards.

Lastly, some of the wounds in the tissues show a remarkable degree of infection which defies most of the methods adopted to clear them. In the worst of these cases sulphur mixed with glycerine is peculiarly effective. The method was discovered as an alternative to the iodoform method of treating T.B. abscesses, for in the latter method intolerance as an idiosyncracy was not uncommon, and death had been produced. It was said that sulphur was only soluble in CS_2, and as none of this was present in the body, that sulphur could not be efficient at all; however, it was tried on T.B. abscesses with the result that in a few days a powerful smell of HS and SO_2 was observed, the tissues round the abscess were corroded, and the T.B. quite destroyed. It would appear that under the influence of living tissues nascent sulphurous acid is produced. Further applications yielded the fact that the method was only useful for T.B. abscesses and chronic suppuration that would not clear up; fresh wounds are little benefited by it. In this war many cases are recorded where limbs have been despaired of and saved by filling up with sulphuric glycerine for some hours.

Recent wounds are best treated by the method of Sir Almoth Wright, who advocates

perfusion with slightly hypertonic saline; the effect is that fluid exudes into the wound partly by osmosis and partly because of the irritation, and with the fluid come crowds of leucocytes, which are the natural protective organisms. But in old cases sulphur acts where most other things fail.

To Geoffrey:—A Scout.

(Patient at "Guy's.")

I know a dear Nurse
And she knows a dear boy
(I am writing this verse
For her sake and her joy);

And she tells me, these days,
He is captive awhile,
Needing care—but she says
With a confident smile

"*He is safe!*" (Her beloved
Alma Mater is "*Guy's*,"
Where the nurses are proved
And the doctors are wise) . . .

But I hear you're a Scout—
And an eager one too!
You must long to be out
With such business to do?

Still—a Scout is a chap
(Or so I've been told)
Who meets every mishap
With a heart that is bold:—

He is kind, he is glad
To be helping along
The feeble—the sad,
With a hand that is strong.

So Geoffrey, you'll find
Within hospital walls,
Many tasks to your mind,
Many needs, many calls!

And when you are well
And have passed on your way,
Ah, who can foretell
What the patients will say

Of the scout who was glad
To be helping along
The feeble—the sad,
With a hand that was strong?

MAUDE ROBERTSON HICKS.

From Chemical Department.

IN addition to two papers referred to in a recent issue of the GAZETTE as having been completed in connection with a Research Scholarship in Dental Metallurgy, the following papers have been published recently from the Chemical and Physical Laboratory of the School:—

THE ROTATORY DISPERSIVE POWER OF ORGANIC COMPOUNDS.

Parts I., II. and III. issued in 1913.

Parts IV. and V. issued in 1914.

Part VI. Complex Rotatory Dispersion in Ethyl Tartrate. By T. M. Lowry and another. (Trans, Chem. Soc., 1915, *107*, 1173–1187.)

Part VII. Complex Rotatory Dispersion in Methyl Tartrate. By T. M. Lowry and H. H. Abram. (Trans. Chem. Soc., 1915, *107*, 1187–1195.)

Part VIII. An exact definition of Anomalous Rotatory Dispersion. By T. M. Lowry. (Trans. Chem. Soc., 1915, *107*, 1195–1202.)

THE SILVER VOLTAMETER.

Part III. The Solvent Properties of Silver Nitrate Solutions. By T. M, Lowry [and in part R. G. Parker]. (Proc. Roy. Soc., 1914, A. *91*, 53–71.)

NITROCAMPHOR AND ITS DERIVATIVES.

Part VIII. The Action of Formamide on Nitrocamphor. By T. M, Leary and V. Steele. (Trans. Chem. Soc., 1915, *107*, 1033–1043.)

NEW HALOGEN-DERIVATIVES OF CAMPHOR.

Part I. *a'*-Chlorocamphor: with a note on Isomerism, Static and Dynamic, By T. M. Lowry and V. Steele. (Trans. Chem. Soc.. 1915, *107*, 1382–1396.)

The action of Normal and Basic Lead Acetates on the Sugars, with remarks on Rubner's Test for Dextrose and Lactose. By H. Rogerson. (Biochemical Journal, 1915, *9*, 245–252.)

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

SIR,—Recently there were published in the GAZETTE some cases seeming to show a connection between herpes zoster and chicken-pox. The following has come under my notice:—On November 3rd a "nurse-housemaid" consulted me for herpes and pain in the right arm. On or about November 17th a little girl, aged 4, who was looked after by the patient, developed chicken-pox.—

Yours truly,
G. G. DAVIDSON

2, Baron's Court Road, W.
29th November, 1915.

L'espion Malgré Lui.

II.—THE PENALTY.

The story is extant, and writ in very choice Italian.
—Hamlet, act iii., scene 2.

June 30th.—The night is heavy with the promise of rain. From without my heavily-barred window comes the sound of a softly tinkled mandoline, and the cut-throat in the next cell catches up the refrain and sings softly enough the rough couplets

**Vede o' mare quantu bello,*
Spira tantu sentimento,
Comme tu a chi tiene mente,
Ca scetato o fare sunnà.

Heavy as a perfume hangs the melody, and as the last lines are repeated the singer lowers his voice to a languorous incantation.

†O! Tornà a Surriento,
Famme campà!

The rain breaks, falling with sonorous thuds upon the huge fig leaves around the window and plashing gently upon the prison bars. Abruptly the mandoline ceases, and for a while the stillness is broken only by the raindrops and the buzzing of a huge beetle around the candle flame, ending with the splutter of his immolation. In a distant studio a piano is played, first at random, then with weird appropriateness the twinkling harmonies of Debussy's "*Jardins sous la pluie.*" The raindrops and the music mingle, ebb and flow, and softly die. After that there is again a deep silence. . . .

I have been here about a month now, and things have settled down to a regular monotony. Really, there is a lot to be said for prison life. Outside one is troubled by a thousand distracting details, bills to be paid, work to be done, letters to write, here one wakes in the comforting security that each day will be exactly like the one before and the one after, and the result is not at all unpleasing. It is only restless people who have time to be *blasé*. Who ever heard of a *blasé* farm labourer, and certainly no prisoner who values his peace of mind would ever get bored. In some respects I have special treatment. I have a cell to myself, a long, bare, whitewashed apartment, lofty as are all Italian rooms, with a window at one end and a door at the other. The jail itself is an old building that has passed through many vicissitudes—a school, a hotel a wine vault, and now a prison. The precautions against escape are childish; no one is expected to try to get away, our old gaoler would take the attempt as a personal affront, and, besides, there would be nowhere to escape to. It would be impossible to leave the island, and refuge on it there is none. So that I and my two companions are left very much at liberty, and the bolting and barring of our doors a perfunctory formality. All my meals are sent in from the hotel where I was staying, luxurious repasts for the most part, prepared by the proprietress herself, whose heart has been touched by the sad plight of the unfortunate signor. Often I find in my breakfast basket a little note, bidding me be of good cheer, a few flowers, some little dainty. My day's programme is simple, and it is always the same: Coffee at eight, which I always take in the open air, after that exercise in the little yard for an hour or so, lunch at 12.30, *siesta* from 1.30 to 4, tea and an airing till 6, dinner at 7.30, bed at 10. Not a complicated programme, but it is wonderful how little events arise to make it interesting. Outside my window is a large garden of vines and figs, the latter laden with the first crop of large green fruit that they call here *fiche dolce*. The other day the owner's daughters, girls of the better peasant type, came armed with large baskets, to gather the ripest of them. Gracious, gentle creatures, of a beauty purely Greek, the *medico Inglese* (it has come to that) of whom all the town was talking, was indeed a source of wonderment to them, and before long we were exchanging the merriest jests, I in as near an approach to the local dialect as I could muster, they in what they presumed was correct Italian. Soon one of them propped the ladder used for gathering the figs against the wall, and I had both hands filled with the luscious fruit. They have promised to come again soon—I hope so. My fellow prisoners, too, are both good fellows, though in private life I am sure they are thorough rascals. The younger of the two, Luigi Bagnato by name, is, I should think, typical of the better class Italian artisan. A little wiry man of forty or thereabouts, full of an exuberant restless vitality, quick tempered, but ordinarily docile as a child, he is an endless source of amusement to myself and the gaoler. He has been in jail three or four times before, always for the same offence, assaulting with the knife, and has already done nearly five years' "time." This time he knows he will be in for a long spell, though out of politeness we all agree that he will be released immediately after his trial. (He actually got 2½ years.) He is a Calabrian, born at Catanzaro, where, if I remember rightly, George Gissing ended his days, and his patois is yet another variety which the earnest student must master. Really there is no end to these dialects! Here in Capri we have at least three, one at the Marina Grande, one in the town itself, and another at Anacapri, with a possible fourth at the Villa Timberio, and throughout the length and breadth of Italy there must be hundreds.

*See how lovely is the sea, breathing forth such passion, that as you watch it, awake, you yet seem to dream.

†Oh, return to Sorrento, and make me live once more.

There has been no universally popular work by a modern author, such as was D'azeglio's "*I promessi Sposi,*" a century ago to mould the language of the people into permanent form. The unification of the country is too recent for all traces of its former divisions to have disappeared, and though all educated Italians speak correctly, yet they always have at their command the local dialect, whilst the common people speak nothing else. It is only in the neighbourhood of Siena and Perugia that pure Italian is universally spoken, and at Rome that the language is spoken with its full musical beauty. *Lingua toscana in bocca romana* (the Tuscan tongue in the mouth of a Roman) runs the proverb, but to the traveller these linguistic differences are a source of endless annoyance. Bagnato is illiterate, a thing much commoner than one would suppose in a country professedly civilised for 40 years; even in Naples public writers are to be seen in the streets, writing letters at the dictation of peasants who have no other means of communication with their friends. In country districts as many as from 10 to 15 per cent. of young men are unable either to read or write. Indeed there seems to be little or no check upon parents removing their children from school at as early an age as they wish if they can show that the exigencies of work in the vineyards call for their services. The natural result of this widespread ignorance is an enormous number of crimes of so extraordinary and calculated brutality that the blood of the Northener boils at the mention of them. The Italian mind is a curious blend of the sentimental and the bestial, and the comparative leniency of the judges to cases of rape, incest. malicious disfigurement, and hooliganism, where it can be shown that the criminal was labouring at the time under strong mental excitement, does not go to remedy matters. In Naples it is, of course, a criminal offence to carry a knife or revolver, but the order is universally disregarded; every day brings its tale of sanguinary fights, foot-paddings, and shooting forays, any one of which would provide London with a sensation for a week. No Italian regards any stigma as attaching to one of these affairs, and they will say quite unconcernedly of someone, "*Ha fatto tre anni di disgrazia*" (He has had three years of misfortune), much as the poorer classes in England speak of a friend being "in trouble." There is a regular scale of punishments based, not on the circumstances of the assault, but on the length of time the lesions inflicted take to cure. Thus, a first offence for wounds probably curable in ten days is about three months, in fifteen days six months, and so on. Vicious attacks on women with a view to disfigurement are so common as to provoke no indignation, and a young fellow who has hideously marked a sweetheart who has rejected him can generally count on being out again in a year or so. In the case of Bagnato the matter was aggravated by his three previous convictions, and the fact that there were two victims, one curable in ten, the other in twenty days, with a permanent scar. Still, it was felt that he had been harshly dealt with. The other prisoner is an elderly man of 65 or so, a cunning, dirty old fellow, whose name I have never known. We called him alternately *o' vecchierello* (the little old man) or *o' pozzuolano* (the man from Pozzuoli). Both appellations seem to serve equally well. He is fairly quiet and serves as a butt for Bagnato, who contrives to make his life a burden. He is in for stealing a pair of old boots, his first offence, and has already been waiting two months for trial. However, he remarks philosophically that he is at least rid of his wife and has enough to eat without working for it, so there is no hurry about things. When not asleep he passes his day in reading my evening paper of the day before through a pair of horn glasses, one lens of which is missing. The *bonne-bouche* is generally declaimed aloud to Bagnato, the gaoler, and myself, a ghastly serial entitled the "Parisian Adventuress: or the Dressmaker of the Via Medina." I have never quite got the hang of the plot, but it seems to be pretty good fun anyway. Apparently living in the midst of blood and turmoil gives one an unlimited appetite for more.

My release does not seem to be approaching with the rapidity I could wish. An *avvocato* has been engaged for me, who represents the case as one of extraordinary gravity and complexity and has demanded an advance of L.200 on the strength of it. What the procedure is I have only the vaguest notion. Two days after my arrest a young man came and took a long statement, chiefly with regard to the Christian names and birthplaces of my parents and grandparents of which I knew next to nothing, and then bade me good-bye in an unexpected burst of English. Since then the matter has been in the hands of a gentleman called the *Procuratore del Ré*, who is apparently a kind of examining magistrate and a combination of Voltaire and Doubting Thomas. Every bit of gossip which is retailed in the village is carefully taken down as evidence of the greatest importance, and all the documents and cards of identity which I can produce are held as proofs, not of my innocence, but of the depth of my machinations. At present he is waiting for the report of the London police upon me and has postponed the verdict on the case for twenty days. Nothing moves quickly in the South, justice least of all.

July 10th.—The English consul has just called with a large consignment of novels, presented by the English residents, and some copies of the *Telegraph,* ten days old. Oh, these novels! Up to now I have read 49 of them, six lives of Tory statesmen, and four volumes of reminiscences by retired major-generals. I hardly know which are the least like life—the biographies of the Tory statesmen, I think. But still, the novels are bad enough, and I dream at night of

strong young heroes who pursue heroines of stainless purity (and questionable pasts) through three, four, and five hundred pages of misunderstandings, local colour and bad psychology to plight their troth beneath the twinkling stars. The formula seems simple enough, and any good guide-book will supply a suitable background—no wonder writing is an overcrowded profession. I have just finished one in which the couple got engaged in a submarine stuck fast on the mud in the North Sea somewhere. Unfortunately it was pulled up at the last moment, and they had to stick to their bargain, which must have been salutary though it probably wasn't pleasant. However, as Judge Brack remarks when Hedda Gabler shoots herself, "People don't do such things as that!" which, after all, is just as well. The papers from England aren't very cheerful reading, either, with the miners' strike, the shortage of munitions, and the Dardanelles fiasco, if things go on like this the Italians will begin to repent of their bargain, I fancy.

The heat is becoming terrific and with it the odours of the prison—and the prisoners. The only provision made for washing is a small handbasin, and sanitation is practically non-existent. My ablutions create the greatest surprise, and I had a warning the other day from the gaoler that his son-in-law, who is a chemist, had told him that to wash one's feet more than once a week, even in summer, is to incur the risk of dropsy. As for Bagnato, he has no use for water, as a beverage or otherwise, and he certainly is unlike the blessed Venturini of Bergamons, who, so the legend runs, exhaled a perfume so sweet that men and women struggled round the altar as he gave the Mass, to enjoy the odour he exhaled. The old man has, I am glad to say, been tried and released, but his place is filled by a gaunt fisherman, who sits in a corner all day and spits reflectively. Apparently force of habit must have proved too much for him, for on the night of his arrest he had spat in the eye of a sentry who challenged him on his way home after a drinking bout. However, he serves well as a lay-figure, and every night he acts alternately as judge and jury, while Bagnato, whose trial is approaching, rehearses the speech that is to reveal him as a deeply wronged man. "*Questa donna, Signor judice, questa scelerata!*" he declaims (this woman, milord, this guilty wretch!), and for half an hour we have a torrent of passionate eloquence about nothing in particular, whilst my brave Luigi paces the room like a caged hyena or appeals for mercy with a sob and hands outstretched. An extraordinary blend of childishness and guile, these Southern Italians, accomplished liars, charming companions, faithless friends. There is something intensely likeable in Bagnato for all his rascality. He is an odd job man *par excellence,* has whitewashed the prison inside and out, made a chicken coop and two pairs of slippers out of heaven knows what, and is constantly manufacturing gaudy little snuff flasks out of newspaper, coloured wool, and dried lemon skins. He acts as my valet, cleans out my cell and makes my bed, brings in my breakfast and lays my dinner. A present of a pipe or a bottle of wine makes him happy for half the day. How sad that qualities as admirable as his should be allowed to languish in a county jail for lack of a little early training and foresight! The mosquitos are one of the burdens of existence just now and the slaying of them my only active amusement. But that angry zuzzz-- at night means a night's rest gone, for I have never heard of anyone yet who either caught a mosquito by candlelight or succeeding in sleeping once it had fairly roused him.

Thank heaven the food remains good, and I can sit in the yard by starlight and sip iced claret (6d. a bottle!) and eat cream and *fragole*, that delicious deep-red little fruit, that make our English strawberries seem so insipid by comparison. A wonderful *chef* is Madame Costantina, and rare are some of the surprises she gives me. One day it is large yellow marrow flowers cunningly fried in batter so that one hardly realizes what they are, another day *sepia* (cuttlefish) so disguised that I do not guess until too late the horror I have been eating. If ever my hostess comes to Paris, look to your laurels, *chefs* of the Café Americain and La Pérouse.

July 20th. News at last! The Procuratore has finally given his decision. As far as he is concerned there is no evidence against me sufficient for the matter to go for trial at the assizes. The case has now only to pass to a court of six judges for the decision to be ratified, a formality merely, and in a few days I shall be at liberty. So my *avvocato*, who is overjoyed at what he calls the unusual rapidity of the procedure. In the meantime Bagnato has gone and I miss his singing and the weird music he contrived to extract from a piece of paper and a comb, and the "*Buon giorno, Dottor Fausto, sempre allegro,*" the invariable greeting with my morning coffee.

July 27th. Fresh difficulties have arisen and there seems every prospect of staying here another month. The committee of judges cannot agree over my case. Three are for a full trial, three hold it unnecessary. An eminent counsel has been engaged, the casting vote of the President alone can decide. The suspense is appalling.

July 31st.—A telegram has arrived to say that the case will not be proceeded with and that I may consider myself an innocent person. Scenes of wild revelry amongst the gaoler and the one remaining prisoner, who proceed to drink my health with money provided for that purpose. Later in the day comes an ill-written document from the Questura setting forth that I ——, son of ——, and ——, suspected of espionage and high treason and liable, if guilty, to four years' imprisonment and a fine of five thousand lire, having been examined by the Session of Assizes, have been found innocent, there being insufficient evidence to bring the case for trial. The Questura, the Maresciallo and the

young judge himself come in person to congratulate me. The order for my release will come as soon as the Ministry for Foreign Affairs has been communicated with. In the meantime, "*un po' di patienza caro signore.*" Curiously enough, now that verdict is given I do not experience the relief which I expected. When one has been awaiting a thing every day for two months, its actual arrival is not the delirious affair one might at first imagine. Still I have had enough of prison, and it will be pleasant to have a bath, if nothing else. The morose fisherman, however, is jubilant, and long after I have gone to bed, I can hear him crooning the chorus of the latest war song.

* *Addio, mia bella, addio !*
L'armata se ne va.
E se non partisse anch'io
Sarebbe una viltà !

G. H. F. G.

Papers by Guy's Men.

Lawrie McGavin, F.R.C.S. Eng. : A case of abdomino-perineal excision of the rectum.—*The Clinical Journal*, December 1, 1915.

Headley C. Visick, L.D.S,, D.D.S. : An appliance used in treatment of a simple orthodontic case.—*The Dental Record*, December, 1915.

K. W. Goadby, M.R.C.S., L.R.C.P., D.P.H. Cantab.: A report on the injection of antitetanus serum in tetanus cases.—*Journal of the R.A.M.C.*, October, 1915.

Major B. W. Hogarth, R.A.M.C.: Wounded by a trench bomb.—*Ibid.*

W. Hale White, M.D. Lond., F.R.C.P, Lond.: A clinical lecture on gunshot wounds of the lungs.—*The Lancet*, December 4, 1915.

Capt. J. A. Ryle, R.A.M.C.: Sugar in the treatment of typhoid fever.—*The Medical Review*, December, 1915.

C. C. Holman, M.B., F.R.C.S.: The treatment of some common casualties.—*The Clinical Journal*, Dec. 8, 1915.

A. J. Cleveland, M.D.: Treatment of hæmaturia in children.—*Ibid.*

A. T. MacConkey, M.D., D.P.H.: The prophylaxis of tetanus: a summary.—*British Medical Journal*, Dec. 11, 1915.

H. W. Barber, M.D.: Case for diagnosis.—*Proceedings of the Royal Society of Medicine.*—November, 1915.

H. W. Barber, M.D.: Case of Lichenoid and Nodular Tuberculide.—*Ibid.*

* Good-bye, my love, good-bye !
The army's off to war
And if I don't go with it
What a pity it would be !

Appointments.

Medical School Appointments.

JANUARY–MARCH, 1916.

Dressers and Clerks in Special Departments :—

Throat and Ear, Genito-Urinary, and Children.—Messrs. H, I. Sterne-Howitt, G. E. L. Simons, M. C. Joynt, H. E. Bamber, C, Odam.

Throat and Ear, Skin, and Orthopædic.—Messrs. W. Heckels, W. Burridge, R. S. Millar, A. W. A. Davies, J. F. T. Forbes.

Eyes and Nervous Diseases.—Messrs. de Robillard, E. W. S. Phillips, R. H. C. Pryn, I. Tewfik.

Obstetric Dressers.—Messrs. P. D. Chapman, T. E. Micklem, R. R. Traill, E. A. Leviseur, J. A. V. Campbell, H. S. H. Vertue, G. B. Smith, C. E. Kidnam, B. E. Jerwood, F. N. Sidebotham, F. Carter-Braine, M. J. Vance, H. S. Wacher (Mr. Chapple).

Assistant Surgeons' Dressers.—Messrs. A. Magill, J. R. Cox, F. J. Harrington (Mr. Fagge); J. C. Gie, W. A. Hawes, E. G. Coombes (Mr. Rowlands); W. R. G. Hearnden, S. M. M. Jabir (Mr. Trethowan); S. T. Wong, G. H. Fitzgerald (Mr. Hughes).

Surgeons' Dressers.—Messrs. S. W. F. Underhill, N. A. H. Barlow (Sir W. A. Lane); B. Ramirez, C. R. Hubbard (Mr. Dunn); H. D. Apergis, J. O. R. Montocchio (Sir A. Fripp); J. C. C. Howe, O. Campion (Mr. Steward).

Medical Ward Clerks. – Messrs. J. A. Alcock, L. A. B. Moore (Dr. Hale White); E. H. Bryant, L. Gill (Dr. Shaw); J. A. Berry, E. F. Deacon, W. Walters (Dr. Fawcett); H. Pritchett, R. Le Blanc (Dr. Beddard). O. Halstead, B. C. W. Simpson, L. S. Debenham, N. Kamchorn, G. A. B. Shacklock, C. W. W. Armstrong, T. Fernandez, A. Y. Massouda.

Surgical Ward Clerk.—Mr. W. H. Grace.

Royal Navy Medical Service.

R. P. Ninnis has been entered for temporary service in His Majesty's Fleet.

Royal Army Medical Corps.

The undermentioned appointments have been made :—

Temporary Capt. E. H. Starling, R.A.M.C., has been appointed temporary Major.

Temporary Lieutenants to be temporary Captains :—G. G. Timpson, H. A. Cutler, C. D. Pye-Smith, C. F. Constant, L. F. Dean, R. O. H. Jones, J. A. Delmege.

The following to be temporary Lieutenants: T. H. Edey, W. D. Newland, A. G H. Moore, F. W. Lee.

The undermentioned temporary Lieutenants have resigned their commissions:—D. G. Greenfield, A. Leeming, S. F. Holloway, W. Elwood, A. H. Clough.

Indian Medical Service.

The King has approved the retirement from the Service of Lieut.-Colonel L. F. Childe.

Territorial Force.

South Midland Field Ambulance: Capt. E. E. B. Landon from Attached to Units other than Medical Units, to be Captain.

Northern General Hospital: Lieut. H. J. Smith to be Captain.

London Mounted Brigade Field Ambulance: Henry Fulton (Honorary Major retired, Special Reserve, late Captain, London Signal Companies (Army Troops) Royal Engineers) to be Major.

Home Counties Field Ambulance: Major Arthur T. Falwasser to be temporary Lieut.-Colonel.

Eastern General Hospital: Capt. W. Tyson is seconded.

Home Counties Clearing Station: Capt. G. W. C. Hollist from Attached to Units other than Medical Units, to be Captain.

Lieut. C. H. Edwards, R.A.M.C., has been appointed temporarily to the War Hospital, Stamford Road, Norbury, London, S.E.

Lieut. E. Harden, R.A.M.C., has been appointed to the Millbank Hospital, London, S.E.

Civil.

J. H. Bustead, L.R.C.P. Edin., has been appointed Certifying Surgeon under the Factory and Workshops Act for the Bungay District of the Counties of Norfolk and Suffolk.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Principles of General Physiology. By W. M. Bayliss, M.A., D.Sc., F.R.S. (London: Longmans, Green & Co.), 1915. Price 18s.

This book will prove very welcome to those desirous of obtaining information on the modern advances of physiology. The author uses his term general physiology in a very wide sense, and in some parts it is not always possible to justify the inclusion of certain subjects into the text. The discussion on page 233 concerning the molecular constitution of water as hydrol, dehydrol and trehydrol hardly falls within the province of the physiologists. In the preface, after defining the term general physiology, a point is made of treating physiology independently of its application to medicine. It seems to us that although medicine has learned much from physiology, there would be little difficulty in citing cases where physiological progress has derived much from clinical observation; and in some cases our knowledge of the functions of some organs may be said to be almost completely derived clinically. Whether this separation of physiology from medicine is altogether desirable is doubtful, and although it may at present be impossible to apply the results of colloid chemistry and adsorption phenomena with benefit to medicine, perhaps the date when this will be possible is not far off.

The author being an eminent researcher in the field of physical chemistry, the reader must expect a large part of the book to be devoted to this subject—nor is he disappointed. The ill-understood principles underlying the formation and properties of adsorption compounds are lucidly set out, and to those of us who have attempted to understand the description of "adsorption" as given in the ordinary text-books, chapters 3 and 4 will come as a blessing. A considerable amount of space is given to those parts of the Ionic theory that come into play in physiological research, and the effects of various ions on the different tissues explained as completely as our present knowledge allows.

To such of us as have not the time to read original articles, the paragraphs dealing with the hydroxyl and hydrogen ions supply an enormously felt want, and the interpretation of acid and alkali in terms of hydrogen ion concentration follow naturally. The paragraph dealing with the preservation of the neutrality of the organism should be read by every man in the wards taking an intelligent interest in such diseases of metabolism as come under his notice. The author has the habit of giving great prominence to physical factors in the explanation of vital phenomena, without, at the same time, discussing the views that are of a more vital nature. The explanation of the engulfing of bacteria by leucocytes by alterations in the surface tension seems unwarranted on the little evidence advanced. So too the comparison of change in the organic world to the gradual transmission of radium into heliam shows the mechanist hardly pressed for an explanation, or failing that, a simile.

We feel more at home in reviewing that part of the book more strictly physiological, and on this we can bestow nothing but praise. The author has helped himself generously with the works of eminent researchers in particular directions with great success, and we get in an accessible and readily understandable

form the presen position o such controversial subjects as reflex action, the conduction of the nervous impulse by the nerve, etc. There are chapters dealing with the usual subject hat have separate section relegated to them in the text books. The chapters on the electrical changes in the tissues gives a very good account of electrocardiograph, and will clear up a few of the difficulties men find in understanding the instrument. and the curves it gives. We are accustomed to use the term tone in a loose general way, and when asked what we mean thereby do not exactly know. A perusa of chapter xviii. on Tonus cannot fail to be of benefit, if only to caution us how little understood are the factors determining and maintaining Tonus at the present time.

The author has attempted to make the book a living book, and with great success. The facts are not set out in what students like to call an easy manner. They follow in a logical sequence, and the author does himself an injustice by the inclusion of a summary at the end of each chapter. If the reader has not learnt much by reading through the chapter, the summary will not help him.

The accounts of the various discoveries and controversies form interesting reading, and to those of us preparing for the higher exams. very profitable reading too; this interest is considerably heightened by the many photographs of the physiologists taking part in the strife for knowledge by these means.

As a text-book to the man reading for his second, the book is too advanced, and the same is true even for the primary, but as a book of reference it is excellent, especially when the ordinary text-books fail us. To those of us interested in particular subjects the book is invaluable, firstly on account of the information t gives us itself, and secondly by the excellent bibliography with which the text closes.

Guy's Hospital Physiological Society.

AT a meeting of this Society, held on December 13th, Mr. H. M. Gray read a paper on the Physiology of a Sense of Humour. The writer dealt rather fully with the psychical factors concerned in the production of laughter, and tried to prove the existence of a laughing centre—by its close analogy with vomiting! The discussion which followed ranged from Bergson to mothers-in-law, and Dr. Pembrey gave some interesting personal details with regard to the latter, going to show that they are not so black as they are painted. The chief point brought out in the debate was the close connection between a sense of high humour and an active and often beneficent criticism of life and manners, as evinced in the works of Swift, Shaw and Samuel Butler. Though at the same time in the act of laughing we cast aside for the moment all sense of pity. At the time when we left the meeting was occupied with the supposed deficiency of a sense of humour in Scotchmen, but we are assured that it ended with a hearty vote of thanks to all concerned. It was fairly well attended, but we would like to impress upon all members the necessity for attending the meetings if possible, so that this session of the Society may be made a success, in spite of the troublous times through which we are passing.

G. H. F. G.

Chapel Notices.

CHRISTMAS.

On Christmas Day there will be celebration of the Holy Communion at 6, 7 and 8.45. On the Sunday after Christmas some Carols will be sung at Evensong instead of the Sermon. There will be a practice on Saturday, December 18th, at 8.15 p.m., to which everyone is invited.

The "Lang-sufferin Doctor."

In the "Sma Hoors."

YEN early morn I was caaed oop by a gret ringin o' the nicht bell. 'Twas aboot 2 a.m., therefore I was na too ameeable in ma timper.

A relateeve o' a prim body had jest depairted on her last lone joournie and the Gowk speered for a certeefeecate. Said I, "Ye canna have yen the now; ye maist coom in the morn at 9.30." Hooiver, he came reinging nicht bell agin in a quarter of an hoor. "Hullo, halloh, *hello!*" said I. "D'ye ken wha ye're deeing?" "Ah," said he, I want the certeefeecate for Mistress McTobie's deed!" "Ah," said I, "Ye may gan to the deuce and hangman! or cam here at 9.30" (which he did apologising). "A' wheel, I canna be bothered at sma hoors by a bleeter like sich an yan.—Yours, NOT SCOTCH.

Marriages.

COOKE—CASSON.—On the 9th October, 1915, at St. Matthias' Church, Richmond, Ernest James Cooke, M.R.C.S., L.R.C.P., to Katherine Alice, second daughter of Mr. and Mrs. Casson of Apsley House, Richmond, Surrey.

EAGLETON—WOOD.—On the 23rd November (very quietly), at Goring-on-Thames, by the Rev. H. G. Nind, great-uncle of the bridegroom, Arthur Joseph Eagleton, M.B., Capt. R.A.M.C., son of the late J. G. Smith, Barrister-at-Law, Chief Judge, Court Small Causes, Madras, and Mrs. Smith, Hillside, Goring-on-Thames, grandson of the late Joseph Eagleton, M.D., and the late Arthur Smith, of The Grotto, Basildon, Berks, to Mabel, youngest daughter of the late Mr. and Mrs. W. Wood, of Barnsley, Yorks.

Death.

EAGER.—On December 1st, Reginald Eager, M.D., late of Northwoods House, Winterbourne, Bristol.

F. A. K.